Lori T Candrian, M.S., L.P.C. 105 N. Gordon, Suite 202, Alvin, TX 77511 Phone: 281-585-0000 Fax: 281-585-0080

Special Instructions: While you may have registered online, please download, print, complete and bring the following forms to your first appointment. These forms contain required information and ask for your signature.

Please note, I accept CASH, CHECK and CREDIT CARDS, for payment not covered by EAP or Insurance.

OFFICE PRACTCES AND POLICIES

The information below is intended to inform you about office practices and policies. Because your relationship with your therapist is based on confidence and trust, it is important that you be fully informed of some of the key elements of that relationship. Though the following list may be daunting, please be assured I will be happy to discuss these policies in detail so that you may feel comfortable with them. This form also serves to document that these policies have been discussed. I will be happy to answer any questions you may have and provide a copy for you to keep.

I have an independent private practice, and while I share office space with other mental health practitioners, each clinician represents an independent private practice.

Emergencies: Messages can be left on my voice mail by calling 281-585-0000 ext. 1. Calls are returned between 8:00 a.m. and 6:00 p.m., Monday-Friday. I make every effort to return calls within 24 hours. After hour calls are reserved for urgent situations ONLY. If you have an ***urgent*** situation and must speak with me immediately, please leave a message on my voice mail and state it is urgent. I will call you back as soon as possible. I recommend that you dial 911, go to your local emergency room or contact your primary care physician in life threatening emergencies. Do not email regarding emergencies.

Goals of Therapy: Goals of treatment will be developed in discussion between Lori Candrian and you. Therapy is a joint effort between the therapist and the client, the results of which cannot be guaranteed. Progress depends on many factors including motivation, effort, consistent attendance, work outside of therapy (assignments) and other life circumstances such as interactions with family, friends, and other associations. It is important to review the work toward meeting these goals and make revisions as needed.

Risk of Treatment: Medicines often have their side effects; in a similar manner there are risks associated with seeking psychological services. For example, as you begin treatment you may become more anxious or experience increased temporary family or relationship conflict. It is normal to feel somewhat reluctant to talk about personal problems with someone you have just met, but this feeling tends to decrease as you become more familiar with your therapist. Although most people report benefits from psychotherapy, a minority feel their conditions worsened as a result of treatment.

Length of Treatment: The length of treatment will be determined in discussion between Lori Candrian and you. Insurance benefits may impact length of treatment. You may withdraw from treatment at any time. If you elect to stop treatment, I will, if you wish, provide you with the names of other practitioners with whom you may want to continue treatment.

Appointment Times: Appointment times are limited. Each session is 45-50 minutes unless special arrangements are made. The first 440 to 45 minutes are spent addressing the presenting problem with the last 5 minutes used to summarize the session and plan for the future.

Missed Appointments: Appointment times are reserved for YOU. If you do not keep your appointment or do not cancel 24 hours in advance, **YOU will be charged a $75.00 No Show/Late Cancellation fee which is due prior to or at the time of your next appointment.** You are responsible for rescheduling missed or cancelled appointments. If you miss two consecutive sessions without informing or contacting me, I will assume that you wish to terminate services. You may terminate services any time by notifying me.

Fees and Payment Information: My professional fee is $160.00 for initial interview, $140 for 53 to 60 minute session, $120.00 for a 45-50 minute session, $80.00 for 30 minute session. Different fee arrangements have been negotiated with some insurance companies. Payments for services or insurance co-payments/deductibles are discussed at your first session. Occasionally, co-pays/deductibles are not available until after the first billing and you are responsible for any difference. The following fees are paid by the client and cannot be billed to your insurance/EAP: $75.00 for No Show/Late Cancellation, $200.00 for Letter of Treatment Summary for Legal Purposes, $100 for Letter of Treatment Summary for educational or other non-legal purposes, $50.00 plus $1.00

per page over 10 pages for Copy of Treatment Records (except for continuity of care), $30.00 charge for returned checks, $30.00 per 15 minutes for after hours, non-emergency phone consultation. See below for fees associated with court appearances.
Payment may be by CASH, CHECK OR CREDIT CARD and is due at the time services are rendered. ***I reserve the right to seek collections for delinquent accounts. I will work with you in every way possible to avoid such an event.***

Confidentiality: The information you provide to Lori Candrian and to those under her supervision is confidential and will generally be released to others only with your written consent. However, I am required by law to disclose confidential information even without your consent in certain circumstance. These circumstances include but are not limited to the following: If I consider you to be a danger to yourself or others; if you are a minor, elderly or have a disability and I believe you are a victim of abuse; if you report to me that a previous helping professional engaged in a sexual relationship with you; if you are involved in any suit or court proceeding affecting the parent/child relationship; if you file suit against the therapist for breach of duty and if court order or other legal proceeding or statue requires disclosure. If you chose to file insurance or work with a managed care company or EAP information regarding your treatment, diagnosis, and the specified issues for which you have come to treatment are available to the insurance company, managed care company or EAP. Health insurance companies often require that I diagnose your mental conditions and indicate you have an "illness" before they will agree to pay for services. In the event a diagnosis is required, I will inform you of the diagnosis I plan to render before I summit it to the health insurance company. Any diagnosis made may become a part of your permanent insurance records. Once the information is turned over to the insurance company, managed care company or EAP, I have no control over how the information may be used. You have the opportunity to discuss with me any questions you may have on the limits of confidentiality. Please also refer to the HIPAA Regulations.

Court Appearances: My focus in providing psychotherapy is on treatment and on healing. It is not my intention to become involved in cases that require my testifying in court. However, should this service be needed, forensic or legal work in terms of paperwork, research, preparation and calls the following rates will apply. Preparation for court including gathering records and phone calls with client/attorney will be billed at a rate of $200 per hour, plus additional fees listed above for records or treatment summaries. All must be paid prior to court appearance. Court appearances will require a $1000.00 retaining fee to be paid a week prior to the court date. The fee for court appearances will be billed for a minimum of a 3 hour time period at $600.00 plus mileage (0.55 per mile) and travel expenses. Any court appearance over 3 hours will then be billed at $200.00 per hour plus the additional costs listed previously.

Management of Records: In the unlikely event of this provider's death I do give permission for any and all records to be turned over to the care and responsibility of Samantha R. Candrian, BS, daughter of Lori T. Candrian, MS, LPC. If this provider and her daughter were to die together, I give permission for any and all records to be turned over to colleague Stephanie K Wilkes, LCSW, PLLC immediately. These records will be kept according to the guidelines of The Texas State Board of Examiners.

Social Media: Including but not limited to Facebook, Instagram, and Twitter may be used by therapist as a tool for marketing services and disseminating information. Social media of any kind are **not** secure in terms of privacy and confidentiality. Therapy is not provided via social median. Private message delivered via social media will not be acknowledged. Emergencies delivered through social media will not be acknowledged. If you have an emergency, do not contact me through social media or email, call 911 or go to the nearest emergency

I have read and agree to the above policies.

Client Signature: _____Date:_____

Client Signature: _____Date:_____

I am signing as Parent, Guardian or Legal Representative Signature:

_____Date:_____

Representative Relationship to the Client: _____

Counselor: _____Date:_____

Lori T Candrian, M.S., L.P.C. 105 N. Gordon, Suite 202, Alvin, TX 77511 Phone: 281-585-0000 Fax: 281-585-0080

PROFESSIONAL STATEMENT

I am pleased you have selected me as your counselor. This document is designed to inform you about my background and to ensure that you understand our professional relationship.

I am a licensed professional counselor in the state of Texas. I hold a Master of Science degree in Guidance and Counseling from Texas A&M University-Commerce. I primarily see individuals age 10 through adult with personal growth issues or mental health disorders I also provide couples and family counseling. A variety of therapeutic techniques are used to connect with each individual including Cognitive Behavioral Therapy, Client Centered Therapy, Psychoeducation, Play Therapy, Art Therapy, and other techniques as needed.

I have been a professional counselor since 1990. I accept clients in my practice who I believe have the capacity to resolve their own problems with my assistance or guidance. I believe that as people become more accepting of themselves, they are more capable of finding happiness and contentment in their lives. However, self-awareness and self-acceptance are goals that sometimes take a long time to achieve. Some clients need only a few counseling sessions to achieve these goals, while others may require more. As a client, you are in complete control and may end our counseling relationship at any point. I will be supportive of that decision and provide you names of other practitioners with whom you may want to continue treatment. If counseling is successful, you should feel that you are more able to face life's challenges in the future with less stress and difficulties.

Although our sessions may be very intimate psychologically, it is important for you to realize that we have a professional relationship rather than a social one. Our contact will be limited to sessions you will arrange with me. It would not be appropriate for you to invite me to socials gatherings or ask me to relate to you in any way other than in the professional context of our counseling sessions. Your needs will be best served if our relationship stays strictly professional and if our sessions concentrate exclusively on your issues or concerns. You will learn a great deal about me as we work together during our counseling experience. However, it is important for you to remember that you are experiencing me in my professional role.

I assure that my services will be rendered in a professional manner consistent with accepted ethical standards. If at any time for any reason you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report your complaints to the Texas State Board of Professional Counselors in Texas at 1-800-942-5540.

If you have any questions, feel free to ask. Please sign and date the next page. You may request a copy for you to keep for your records.

CLIENT/COUNSELOR CONTRACT AND ACKNOWLEDGEMENTS

I _____ commit to enter into a counseling relationship. In doing so I am personally committing to do the following:

A. Keep all scheduled appointments unless circumstances beyond my control prevent my attendance. I will be responsible for rescheduling missed appointments.
B. Participate in the counseling process honestly and to the best of my ability.
C. Complete any self-help assignments that I have agreed to carry out.
D. Apply any skills that I have gained to improve the quality of my life and the life of those around me.
E. I will notify my therapist of any significant changes or problems that may impact my work in therapy.

Acknowledgement: I have read and understand the Professional Statement, and the Client/Counselor Contract and I recognize that I have the opportunity to discuss any questions I may have.

Client Signature: _____Date:_____

Client Signature: _____Date:_____

I am signing as Parent, Guardian or Legal Representative Signature:

_____Date:_____

Representative Relationship to the Client: _____

Counselor: _____Date:_____

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NOTICE OF PRIVACY PRACTICES – BRIEF VERSION

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

My commitment to your privacy:

My practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. I am also required by law to keep your information private. These laws are complicated, but I must give you this important information. This handout is a shorter version of the full, legally required NPP which you may request to review for more information. However, I can't cover all possible situations so if questions arise please talk to me about any questions or problems.

I will use the information about your health which I get from you or from others mainly to provide you with treatment, to arrange payment for my services, and for some other business activities which are called, in the law, health care operations. After you have read this NPP I will ask you to sign a Consent Form to let me use and share your information. If you do not consent and sign the form, I cannot treat you.

If I or you want to use or disclose (send, share, release) your information for any other purposes I will discuss this with you and ask you to sign an Authorization form to allow this.

Of course I will keep your health information private but there are some times when the laws require me to use or share it. For example:
1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization that is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires me to do so.

4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask me to call you at home and not at work to schedule or cancel an appointment. I will try my best to do as you ask.

2. You have the right to ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends. While I don't have to agree to your request, if I do agree, I will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information I have about you such as your medical and billing records. You can even get a copy of these records but I may charge you. Ask me to arrange how to see your records.

4. If you believe the information in your records is incorrect or missing important information, you can ask me to make some kind of changes (called amending) to your health information. You have to make this request in writing and send it to me. You must tell me the reasons you want to make the changes.

5. You have the right to a copy of this notice. If I change this NPP I will post the new version in the waiting area and you can always get a copy of the NPP from me.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with me or with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care I provide to you in any way.

If you have any questions regarding this notice or my health information privacy policies, please contact Lori T. Candrian (Privacy Officer) who can be reached by phone or mail at the above number and address.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health and Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201
(202)-619-0257 Toll Free: 1-877-696-6775. The effective date of this notice is April 14, 2003.

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CONSENT AND DISCLOSURE

(Protected health information for treatment, payment or health care operations)

This form is an agreement between you, _____ and Lori T. Candrian, M.S., L.P.C. When I use the word "you" below, it will also mean your child, relative, or other person if you have written his or her name here: _____

When I examine, diagnose, treat or refer you I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let me use your information and send to others. The Notice or Privacy Practices explains in more detail your rights and how I can use and share your information. Please read the Notice of Privacy Practices before you sign this Consent form.

If you do not sign this consent form agreeing to what is in my Notice of Privacy Practices, I CANNOT treat you.

In the future I may change how I use and share your information and so may change my Notice or Privacy Practices. If I do change it, you can get a copy from me by calling me at the above number or by asking me in person.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but I may already have used or shared some of your information and cannot change that.

Signatures for Consent to use and disclose your protected health information for treatment, payment or health care operations and verification that Notice of Privacy Practices – Brief Version was received:

Client Signature: _____Date:_____

Client Signature: _____Date:_____

I am signing as Parent, Guardian or Legal Representative Signature:

_____Date:_____

Representative Relationship to the Client: _____

Counselor: _____Date:_____

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CONSENT TO RELEASE TO PSYCHIATRIST OR PRIMARY CARE PHYSICIAN

If referred by a Psychiatrist or Primary Care Physician (PCP) and/or if you would like Lori T. Candrian, M.S., L.P.C. to receive/provide treatment information from/to your Psychiatrist or PCP.

Client Name:_____DOB:_____

I give my permission for Lori T. Candrian, M.S., L.P.C. to provide/receive information concerning my treatment to/from

_____

Address: _____

Phone: _____ Fax: _____

_____ I do not wish treatment information to be given to my Primary Care Physician.
_____ I do not wish treatment information to be given to my Psychiatrist.

_____ _____
Client Signature Date

To: _____

From: Lori T. Candrian, M.S., L.P.C.
I am currently seeing the patient named about for:
_____ Individual Therapy _____Marital Therapy _____Family Therapy

The patient's initial Axis I diagnosis is:
_____ Major Depressive Disorder_____
_____ Bipolar Disorder_____
_____ Generalized Anxiety Disorder_____
_____ Adjustment Disorder with _____
_____ Other: _____

I have requested that the patient see you for:
_____ Evaluation for psychotropic medication
_____ Medication Management issues
_____ Physical Examination/Lab Work _____
_____ Other: _____

Other Concerns/Issues:
_____ This is for information only _____Description of concern/issue
_____
_____
_____
_____
_____
_____
_____
_____

Signature: _____Date:_____

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MEDICAL INFORMATION

Client Name: _____ Date: _____

Previous Mental Health Treatment: _____Yes _____No

Explain: _____

Referring Physician/Psychiatrist: _____

Date of Last Physical: _____

Major Illnesses/Diagnosis: _____

_____

Medications: _____

_____

Relevant Family Information: _____

_____

Are you allergic to any medications or have you ever experienced adverse reactions to any medications?
_____Yes; Describe: _____
_____No

Are you currently under the care of a physician for any medical problems, or are you experiencing any medical problems that you are concerned about?
_____Yes; Describe: _____
_____No

Have you been treated for any significant medical problems in the past?
_____Yes; Describe: _____
_____No

Client Signature: _____ Date:_____

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ASSIGNMENT OF BENEFITS/REQUEST FOR DISCLOSURE/MERGENCY CONTACTS

Client Last Name: _____

Client First Name: _____

Client DOB: _____

Release of Information: I authorize the release of any medical information, including diagnosis, or other information necessary to process this claim for services. I realize Lori T. Candrian, M.S. L.P.C. may be required to release parts of my record and/or discuss my case with my insurance carrier or authorized insurance review committee to receive payment, obtain additional authorization for services, or for case audit. I also request payment of government benefits either to myself or Lori T. Candrian, M.S., L.P.C.
Client or Authorized Person's Signature_____

Assignment of Benefits: I authorize payment of medical benefits to Lori T. Candrian, M.S., L.P.C. for services provided. I understand I am financially responsible for charges not covered by insurance (co-pays. percentages, deductibles, no-show fees when applicable, or non-payment due to failure to provide information regarding changes in insurance coverage. I understand that Lori T. Candrian, M.S., L.P.C. reserves the right to seek collections for balances due by me.
Insured's or Authorized Person's Signature_____

PATIENT REQUEST FOR DISCLOSURES: In general, the HIPAA privacy rule gives individuals the right to request confidential communications of Public Health Information (PHI) be made by alternative means such as sending correspondence to the individual's place of employment instead of their home. All efforts will be made to comply with these requests.
I wish to be contacted in the following manner:
Detailed messages may be left on answering machine, voice mail or with a person at the following number(s). Please write number(s) and indicate if home, cell, work or other number.

Name and number ONLY may be left on answering machine, voice mail, or with a person at the following number(s). Please write number(s) indicate if home, cell, work or other number.

Written Communication may be mailed to my home address: _____YES_____NO
Electronic Communication via unencrypted email: _____YES_____NO
Information may be send via unencrypted text to the cell number on record: _____YES _____NO
Information may be faxed to:_____

In case of emergency please contact:
Name_____Phone_____Relationship_____

Client or Authorized Person's Signature:_____Date:_____

Lori T Candrian, M.S., L.P.C. 105 N. Gordon, Suite 202, Alvin, TX 77511 Phone: 281-585-0000 Fax: 281-585-0080

APPOINTMENT REMINDERS AND ONLINE SCHEDULING

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments.

You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit **www.therapyappointment.com** to schedule or reschedule your appointments. You may continue to schedule appointments in person or by telephone, but if you have Internet access, you are sure to enjoy the convenience of this online system.

Your name: _____

Your email address: _____

Your cell phone number: _____

Where would you like to receive appointment reminders? (check one)

_____ Via an unencrypted text message on my cell phone (normal text message rates will apply)

_____ Via an unencrypted email message to the address listed above

_____ Via an automated telephone message to my home phone

____ None of the above. I'll remember my appointments on my own. (Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

Client or Authorized Person's Signature: _____

Date: _____

Lori T Candrian, M.S., L.P.C. 105 N. Gordon, Suite 202, Alvin, TX 77511 Phone: 281-585-0000 Fax: 281-585-0080

CREDIT CARD PAYMENT AUTHORIZATION FORM

Client Name: _____Date of Birth:_____
Parent/Guardian Name:_____

I, _____.authorize Lori T Candrian, M.S. L.P.C. to keep my signature on file and to charge my credit/debit card for the recurring charges: Please initial.

_____Co-pay/Co-Insurance in the amount of $_____

_____Private Pay in the amount of $_____

_____I agree for additional charges should insurance EOB reflect a different amount due.

I, _____ authorize Lori T Candrian, M.S., L.P.C. to keep my signature on file and to charge my credit card for the amount of $75 for no shows and late cancellations without 24 hour notice. (This fee will only be waived one time.)

A receipt for any charges will be sent to me via my email address_____

I understand that this form will be renewed in January of each calendar year and is valid for one calendar year unless I cancel authorization in writing.

All information includes sufficient funds, expiration date, valid card number and etc.

By my signature below, I guarantee that I am the account holder and that I agree to the above terms.

Card holder Name: _____

Billing Address for Credit/Debit
Card: _____

Type of Card: _____Visa _____Master Card _____Discover _____Amex

Credit/Debit Card Number: _____

Expiration Date: _____ 3 digit code on back of card _____

Card Holder Signature: _____ Date: _____

Downtown Counseling Services

Lori T Candrian, M.S, L.P.C.

Telehealth Services

As a Licensed Professional Counselor, I can deliver a series of Telehealth programs and services to you. Virtual Sessions will be done via my HIPAA Compliant, cloud-based software platform that allows us to meet over the Internet using a video camera and microphone enabled device. I can provide mental health services to anyone with a computer, broadband Internet connection, webcam, and microphone. Online counseling or "Teletherapy" is when a professional counselor or psychotherapist talks with a client over the Internet to give emotional support, mental health assessment, goal setting and a treatment plan. This process can be one question or an ongoing conversation. Teletherapy is a viable alternative to therapy in person, especially when medical complications or other circumstances limit a person's ability to see a therapist in person. Teletherapy is a source of help when traditional psychotherapy is not accessible. It's effective. It's confidential.

Teletherapy Services Agreement and Informed Consent

As a Client of Lori T Candrian, M.S, L.P.C., I agree to the following:

1. Unless we explicitly agree otherwise, our teletherapy exchange is confidential and the laws that protect the confidentiality of your personal information that you have already signed also apply to telehealth. Any personal information you choose to share with me will be held in the strictest confidence. Just as for my face-to-face clients, I will not release your information to anyone without your prior approval or I am required to do so by law. In Texas, I am required to notify authorities if I become convinced a client is about to physically harm someone; or if they are abusing or about to abuse children, the elderly, or the disabled.

2. You understand that our Teletherapy occurs in the state of Texas and is governed by the laws of that state. In a manner of speaking, you are using this modality (teletherapy) to visit me in my Texas office where we meet to do our work.

3. Helping you build the life you want is what our exchange is all about. We should not continue any process that is counter-productive in that respect. Either of us is free to terminate our relationship at any time and for any reason. Termination of Teletherapy will not affect your right to future care or treatment. If you decide to terminate, I believe it would be to your benefit to write me a short note stating the reasons for your leaving. In the unlikely event I become convinced our Teletherapy is not in your best interest, I will explain that to you and suggest some alternative options better suited to your needs.

4. While Teletherapy is a great way to get help with many of life's problems, overwhelming or potentially dangerous challenges are best met with face-to-face professional support. You understand that our Teletherapy is neither a universal substitute nor the same as, face-to-face psychotherapy treatment. You accept the distinctions made using Teletherapy vs. face-to-face psychotherapy. You accept that Teletherapy does not provide emergency services.

5. You are responsible for information security on your computer. If you decide to keep copies of our emails with telehealth links or communication on your computer, it's up to you to keep that information secure. Unfortunately, I cannot guarantee the security of our unencrypted e-mails as they travel between our computers. It is possible, though unlikely, to intercept e-mails in transit.

6. You understand that there are risks and consequences from teletherapy, despite reasonable efforts on the part of the counselor, including, but not limited to:

- the transmission of your personal information could be disrupted or distorted by technical failures
- the transmission of your personal information could be interrupted by unauthorized persons
- the electronic storage of your personal information could be unintentionally lost or accessed by unauthorized persons.

I utilize secure, encrypted HIPAA compliant audio/video transmission software to deliver teletherapy via VidHealth. If connection is bad, during this COVID-19 pandemic we can use non-HIPAA compliant platforms like FaceTime or Duo.

7. Teletherapy is a means by which you, the e-client, can receive coaching, counseling, information and guidance from an experienced psychotherapist. It is perhaps most accurately perceived as a process creating, over time, a trusting and collaborative relationship. In our collaboration, you retain the right to determine which topics we cover and the depth of consideration each receives. In other words, as an e-client, you are free to contribute or withhold any information you choose. Moreover, you are under no obligation to apply information and/or opinions I contribute to our Teletherapy. While I hope that you will find our exchange useful in your efforts to help yourself and improve your life, it is not possible to guarantee that; despite the ever-increasing positive feedback from e-clients, Teletherapy therapy is best considered experimental until it's efficacy has been validated scientifically. There are no other explicit or implied commitments in our Teletherapy relationship.

8. **Both you and I agree not to record the session without each other's permission.**

9. 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 an emergency, you should:

- immediately call 9-1-1
- seek help from a hospital or crisis-oriented health care facility in your immediate area or
- go to your local emergency room

You may also contact the National Suicide Hotline at 1-800-272-8255 or the 24/7 Crisis Text Line by texting "HOME" to 741741.

Downtown Counseling Services
Lori T. Candrian, M.S., L.P.C.
105 N. Gordon, Suite #202
Alvin, Texas 77511
281-585-0000 x1 F 281-585-0080

PAYMENT FOR TELETHERAPY SERVICES:

Lori T Candrian, M.S., L.P.C. will bill insurance for teletherapy services when these services have been determined to be covered by an individual's plan. The standard co-pay and/or deductibles would apply and be collected at the start of the teletherapy session. In the event that insurance does not cover telehealth, your cost will be charged as an out-of-pocket rate. You may also choose to not bill insurance for this service and pay for this service as a private pay client.

I have read and understand the **Teletherapy Services Agreement and Informed Consent** provided above regarding teletherapy, have discussed it with my counselor, and all of my questions have been answered to my satisfaction. By my signature below, I hereby state that I have read, understand, and agree to the terms of this document and consent to receive teletherapy services. I have also read and signed all other required Intake forms.

My emergency contact person for my therapist to reach if needed is:

Name_____ **Phone:**_____

Client Name: _____ **DOB:**_____

Client Signature: _____ **Date:** _____

I am signing as Parent, Guardian or Legal Representative.

Representative Relationship to the Client: _____

Counselor: _____ **Date:** _____

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Alvin, Texas 77511
281-585-0000 x1 F 281-585-0080

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face
We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, our families, other therapists and other clients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free. ____
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. ____
- You will wait in your car or outside until no earlier than 5 minutes before our appointment time and not bring extra people with you to wait for or during appointment. ____
- You will wash your hands in the restroom before entering the suite. ____
- You will adhere to the safe distancing precautions we have set up in the waiting room.___
- As mask are NOT mandated in Brazoria County, I am not asking you to wear a mask. You are free to wear a mask and ask your therapist to do so, too. You need to notify therapist before your appointment. ____
- You will attempt to keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me or others. ____
- You will try not to touch your face, mouth or eyes with your hands. If you do, you will immediately wash or sanitize your hands. ____

- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. ____
- You will take steps between appointments to minimize your exposure to COVID. ___
- If you have a job that exposes you to other people who are infected, you will immediately let me know. ___
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me know. ___
- If a resident of your home tests positive for the infection, you will immediately let me know and we will then [begin] resume treatment via telehealth.___

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website, FB page and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick

You understand that I am committed to keeping you, me, other therapists and other clients, and all of our families safe from the spread of this virus. If you show up for an appointment and I or other therapists in the office believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I or other therapists in the office test positive for the coronavirus, I will notify you so that you can take appropriate precautions. If any clients are diagnosed with COVId-19, we will make every effort to notify other clients that were in the office the previous 14 days.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Downtown Counseling Services

Office Safety Precautions in Effect During the Pandemic

Our office is taking the following precautions to protect our patients and help slow the spread of the coronavirus as we return to face to face sessions.

- Office seating in the waiting room arranged for appropriate physical distancing.
- Therapists maintain safe distancing.
- Restroom soap dispensers are maintained and everyone is encouraged to wash their hands for 20 seconds and completely drying before entering the suite.
- Hand sanitizer that contains at least 60% alcohol is available in the offices, the waiting room and at the reception desk.
- We ask all patients to wait in their cars or outside until no earlier than 5 minutes before their appointment times and to not bring additional people to their appointment to wait.
- We ask you bring your own pen to each session.
- Physical contact is not permitted.
- Tissues and trash bins are easily accessed. Trash is disposed of on a frequent basis.
- Offices and common areas are disinfected at approximately noon and at the end of each day.
- Play therapy rooms have detailed disinfecting protocols.

I have read and understand the information provided above regarding returning to in person services, have discussed it with my counselor, and all of my questions have been answered to my satisfaction. By my signature below, I hereby state that I have read, understand, and agree to the terms of this document and consent to resume in person services.

Client Name: _____ **DOB:_____**

Client Signature: _____ **Date: _____**

I am signing as Parent, Guardian or Legal Representative.

Representative Relationship to the Client: _____

Counselor: _____ **Date: _____**