H. Ameeta Singh, MFT #50409
Licensed Marriage and Family Therapist

REGISTRATION FORM:

Client Information:

Today's Date: _____/_____/_____

Name: ______________________________ *D.O.B.:* _____/_____/_____

Address: ______________________________

City: ______________________ *Zip code:* ____________________

Home phone: ____________________ *Cell phone:* ____________________

Email: ______________________________

How did you hear about me? ______________________________

Reason(s) for coming to therapy:

____

____

What gender pronoun(s) do you use?

____

Partner/Spouse/Other Parent information: (for couples clients only)

Name: ______________________________ *D.O.B.:* _____/_____/_____

Address: ______________________________

City: ______________________ *Zip code:* ____________________

Home phone: ____________________ *Cell phone:* ____________________

Work phone: ____________________ *Email:* ____________________

Emergency contact:

Name: ____________________ *Tel:* ________________ *Relationship:* ____________________

I authorize contacting this person in the case of emergency:

______________________________ _____/_____/_____

Signature *Date*

OFFICE POLICIES,
AGREEMENT FOR PSYCHOTHERAPY SERVICES,
GENERAL INFORMATION & RESOURCES

This information has been prepared for you so that you can have a basic understanding of what our agreement is regarding the psychotherapy services you will be receiving.

This agreement is between:

H. Ameeta Singh, MFT #50409 (Therapist) and

____ (Client).
Print Name

PAYMENT POLICY

Clients are expected to pay the fee for service at each session, unless other arrangements have been made. Payment is through Venmo to @AmeetaSingh. If during the course of therapy, you experience difficulties regarding prompt payment for services, please speak directly with your therapist to discuss the situation.

The fee for your psychotherapy services is $_________

Initial here: ____________

ATTENDANCE & CANCELLATION / MISSED APPOINTMENT POLICY

My goal is to provide clients with high quality psychotherapy services. In my experience therapy is very much a collaborative effort between therapist and client. It is most effective when it happens on a regular and consistent basis. As such, it is expected that clients will attend all regularly scheduled sessions. If you cancel your appointment I cannot fill that slot with anyone else. I require 48 hours' notice of cancellation. I am able to accommodate 1 (one) cancelled or missed session every 3 months (which equals 4 sessions a year). If I cancel your session, you will not be charged and it will be rescheduled. There is a $60 fee for all other missed or cancelled appointments beyond the 1 per quarter (every 3 months). You will have to pay this fee to continue with your sessions or if you want me to hold the appointment slot for you in case of extended absences such as travelling. I cannot hold your slot for more than one week at a time or more than once per year. If it appears that you may be struggling to maintain consistency with your appointments, then I am happy to dialogue and problem solve around this with you. In lieu of cancelling, you might want to consider a phone appointment instead.

Initial here: ____________

APPOINTMENT TIME:

Please be on time. I am usually available to begin promptly. If you are late for a session, we will still need to end within the time frame allotted for your session. The charge for these meetings will be the full amount.

Initial here: ___________

By signing below, I acknowledge that I have read and understood the office policies outlined above and have raised any questions I might have about it with my therapist. I have received full and satisfactory response and agree to the provisions freely and without reservations.

_________________________ _________________________

Client Name (please print) Signature

_____/_____/_____

Date

CONSENT FOR TREATMENT

I consent to receiving psychotherapy services from H. Ameeta Singh, MFT #50409. By signing below, I acknowledge that I have read, understand and accept the information and policies outlined in this document.

_________________________ _________________________

Client Name (please print) Signature

_____/_____/_____

Date

GENERAL CONSENT FOR TREATMENT OF A CHILD/MINOR

I am the parent/legal guardian of the child/ren listed below and on their behalf authorize them to engage in psychotherapeutic services with Ameeta Singh, MFT #50409. I understand that the policies set out in this document apply to all the children named below.

_________________________ _________________________

Child's Name (please print) Signature of parent/legal guardian

_____/_____/_____

Date:

INFORMED CONSENT FOR ONLINE VIDEO THERAPY

This form is designed to allow you to give informed consent for the use of video technology for online therapy. Read it thoroughly for understanding and ensure all of your questions are answered before signing to give consent.

This is to be used in conjunction with, but does not replace, the Informed Consent document that is required of all clients prior to starting therapy services.

Online therapy or teletherapy is defined as the use of technology to have a therapy session. We will use Thera-LINK, a HIPAA compliant platform that uses video and audio technology through a webcam on your device and my device to connect us securely.

Thera-LINK uses encrypted data streams (AES-256) for our video sessions. Any data that is stored outside of our video session on the Thera-LINK platform (such as documents, messages, or progress notes) is encrypted and meets or exceeds all HIPAA and HITECH guidelines.

The benefits of teletherapy include the convenience of location, time, wait times, and accessibility which allows for better continuity of care. In addition, teletherapy allows for greater accessibility to services for clients with limited mobility or with lack of transportation. Teletherapy can also allow for couples or families to meet when in different locations.

With all technology, there are also some limitations. Technology may occasionally fail before or during our session. The problems may be related to internet connectivity, difficulties with hardware, software, equipment, and/or services supplied by a 3rd party. Any problems with internet availability or connectivity are outside the control of the therapist and the therapist makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video, the therapist will either use the in-session video chat to trouble shoot or will call you back to complete the session. Please write your cell phone number here: ____________________________.

If, for any reason, we are unable to connect and you are in an immediate crisis or a potentially life-threatening situation, get immediate emergency assistance by calling 911.

I AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN COMPUTER AND IN MY OWN PHYSICAL LOCATION. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

I understand that I am not allowed to do any recording, screenshots, etc. of any kind, of any sessions.

CONSENT TO TELE-TREATMENT

I, ___________________________________(insert name) voluntarily agree to receive online video therapy services for assessment, continued care, treatment, or other services and authorize H. Ameeta Singh, LMFT #50409 to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through H. Ameeta Singh, LMFT #50409 at any time. I understand H. Ameeta Singh, LMFT #50409 will determine on an on-going basis whether the condition being assessed and/or treated is appropriate for online therapy.

By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Print Name: ___________________________________

Signature: ___________________________________ Date: __________________
(client/parent/conservator/guardian)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given to you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at:
(415) 203-3807/ ameetasingh@healingchange.org

If you have any questions about my Notice of Privacy Practices, please contact me at:
415-203-3807/ ameetasingh@healingchange.org

I acknowledge receipt of the Notice of Privacy Practices of H. Ameeta Singh, MFT #50409.

Print Name: ______________________________

Signature: ______________________________ Date: ________________
(client/parent/conservator/guardian)