**Client Information Form**

**I assure you that I read every bit of the information you give me. Thank you for your time and information.**

|  |
| --- |
| Name: |
| Address: | City: | State: | Zip: |
| If you are meeting me virtually from a different address than above, please write it here:  | Age: |
| I agree that Chris Quaglino can bill LYRA and understand that if LYRA requests mental health updates he may be required to supply this information. | Initial Here: |

|  |
| --- |
| **\*Optional Demographic Information** |
| Gender: | Female: | Male: | Self: | Preferred pronouns:  |
|  |  |  |  |
| **Client Contact Information and Permissions:****You are responsible if others access your electronic communication with me or if they look over your shoulder.****Also note that electronic communication could be subpoenaed and is a permanent record.** **Please complete the Client Communications Agreement at the bottom of page 4.** |
|  |
| Please check all that apply: | Single | Married/Partnership | Divorced/Separated | Widowed |
| **Emergency Contact** |
| Name: | Relationship to you: |
| Best Phone Number (Daytime): | Best Phone Number (Nighttime): |
| Address: | City: | State: | Zip: |
| **Family Information** |
|  | Name(s) | Age(s) | Name(s) | Age(s) |
| (Ex)Spouse/Partner |  |  |  |  |
| Children |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| Siblings |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| Parents |  |  |  |  |
|  |  |  |  |  |

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| Sometimes Therapy is Not Easy |
| The process of therapy can be stressful and sometimes overwhelming. To help this process to be as productive as possible, an important therapeutic partnership must be established between you and your therapist in which good self-care routines are established. Please help me to understand more about you by providing the information listed below at the first session. |
| Optional Pre-Service Questionnaire |
| Please list the top areas of current concern for you that you would like or need to work on: |
| Please tell me a little bit about your history (pertinent information concerning your family and relationships history, significant loss): |
| Do you feel like you have resolved any of these issues? How? |
| Have you suffered a traumatic event? Please Circle: Car Crash Natural Disaster Assault Deployed Military Service Other (describe). If yes, what and when? |
| What do you hope to get out of our sessions? |
| What are your strengths? |

**Informed Consent**

I understand that all statements made by me to my counselor are of a confidential nature and generally, except as noted below, may not be disclosed by my counselor without my consent. I further understand and accept as a condition of receiving counseling, that certain statements made by me or certain situations may require my counselor to take action or make disclosure when my counselor believes it is necessary for the protection of life or when my counselor may be required by law to disclose or report threats or past instances of harm to myself or threatened harm or past instances of harm to a third person. These disclosures will be made at the sole discretion of the Counselor I am seeing. I hereby acknowledge that I have read and understand the following six items concerning confidentiality of service provided. I understand that if I have any questions regarding privacy rights, I can ask Chris Quaglino, LCSW, LCDC.

**Client Communications Agreement Communication Policy**

The Health Insurance Portability and Accountability Act (HIPAA) gives you, the client, the right to request that your therapist communicates administrative and/or clinical information to you in confidence by a particular method.

In order to protect the privacy and confidentiality of your information, please indicate how you wish to be contacted. **Check and fill in all that apply**:

|  |
| --- |
| **Phone Communication** |
|  Place an ‘X’ in each column that you choose |
|  | Home Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I understand Chris Quaglino will not leave a message that others may hear. |
|  | **Personal** Mobile Phone Number (NOT A WORK PHONE):  |
|  | Yes, Chris Quaglino may leave a message with his name and call-back # on my voicemail because I have my phone password protected and I don’t share the password with anyone. |
|  | I also agree to **only use text for appointment confirmation**. I will not use texting for discussion of any issues or concerns. I will call Chris Quaglino directly with this type of information, leave a message as needed, and Chris Quaglino will return my call. And finally, I know that **if I leave my phone or computer out and/or unlocked for others to see or use, I may compromise the privacy of my personal information. It is my responsibility to keep the information on my electronic devices private. This includes all electronic devises: iPad, Phone, Tablet, Computer, TV incoming calls notices, etc.** |
| **Email Communication** |
|  | I do not wish to communicate via email. |
|  | Yes, I wish to communicate via email. I will **ONLY USE** **the private, personal email address listed below. I will** **never** **use a shared or work email address**. I also understand that work email is the property of the company that I work for and con be used in court. My secure/personal email address is: |

|  |
| --- |
| **Acknowledgements** |
|  Please **initial each space** below acknowledging you have been given, read and understand the following: |
|  | **HIPAA statement (see below)** |
|  | **Informed Consent statement (see above)** |
|  | **Teletherapy** **Informed Consent (see below)** |
| Client Signature (or authorized representative\*) Date |

**Notice of Privacy Practices**

This notice describes how protected health information about you, the client, may be used and/or disclosed, and how you may gain access to this information if necessary. There are federal laws, state laws, and professional ethical requirements that govern your privacy and limitations to confidentiality as the client. I, the therapist, am required to inform you of my privacy practices as it pertains to the Health Information Portability and Accountability Act of 1996 (HIPAA). Due to HIPAA and the state law’s complex nature, I have

simplified and outlined the most relevant information in this notice. This notice explains how I handle information about you: in specific, it details how your information might be used in office, with third parties (e.g. with other professionals, insurance companies etc.), and how you can access your medical information. If you have any additional questions please contact me for clarification.

**WHAT IS PROTECTED HEALTH INFORMATION (“PHI”)**

**PHI is any information that can be used to identify you individually. This may include:**

‣ Personal History (e.g. familial, school, work, marital status, and personal history)

‣ Reasons for Seeking Service (e.g. presenting issues, symptoms, goals)

‣ Diagnostic Information (e.g. medical codes and terminology regarding your symptoms and challenges)

‣ Treatment Plan (i.e. you and your therapists’ collaborative decision on how to best support your needs)

‣ Session Notes/ Documentation (i.e. professional observation recorded during sessions)

‣ Records/ Evaluations from other Healthcare Professionals

‣ Legal Documents

‣ Billing Information

**This information may be used for many purposes, such as:**

‣ Planning for your care and treatment

‣ Progress evaluation

‣ Collaboration with other healthcare professionals working with you

‣ Financial records

‣ Insurance submission

‣ For legal proceedings if subpoenaed by a court of law

It is my professional and ethical responsibility to ensure that your PHI is kept confidential by all means necessary. Knowing what may be in your records and what your PHI may be used for allows you to make educated decisions regarding who, when and why third parties may have access to this information.

**HOW YOUR PHI CAN BE USED AND SHARED**

When I am viewing your PHI, it is considered “in use”. PHI that is shared with any third party is called a “disclosure”. I will only disclose your PHI to a third party with your written authorization, unless the law requires that I do so outside of your consent (e.g., subpoenas, if you are at of risk harming yourself or others, if there is knowledge of abuse or neglect towards a child, older adult, or depended adult).

**Uses and Disclosures That Require Your Consent**

Typically, if I need to share your PHI, it will be for the purpose of providing or coordinating treatment for you, to arrange for payment of services, or for other healthcare-related procedures. In all situations, I must receive written authorization by you in order to disclose PHI. Below are examples of use and disclosure:

1. Treatment: Your therapist uses your information to provide you with counseling and psychological services,

whether for individual, couple, family, or group therapy. In addition, there may be times when it is beneficial for your therapist to consult with others who are also involved in your care (e.g., doctors, teachers, other therapists).

2. Payment: Your therapist may use your information to receive payment for services rendered. This includes credit card information, invoices, or other financial documentation regarding your therapy service. Invoices may include dates and times of appointments, diagnostic information, and similar information insurance companies require to process claims.

3. Healthcare Operations: Your therapist might use your PHI for other purposes, such as researching best practices, or disclosing information to government health agencies. This happens infrequently and your name and all personally identifying information must be first removed.

Uses and Disclosure of PHI Not Requiring Client Consent

In certain situations, the law requires that I disclose some or all of your PHI without your consent or authorization, including but not limited to:

1. Reporting suspected child abuse, elder abuse, or dependent adult abuse

2. If you may be a serious safety threat to yourself or others

3. Upon receiving a court order or other lawful processes that require me to release your PHI

4. If you need emergency treatment and are unable to communicate with me directly

5. Disclosing PHI to consultants (such as attorneys and other professionals) whose legal obligation is to ensure

that I am in compliance with privacy laws

6. If disclosure is otherwise specified by law

**Changing Your Consent**

If you have previously signed an authorization for me to share your PHI and you desire to change or revoke that

authorization in writing, I will cease any future uses and/ or disclosure of your PHI to the extent permitted by law.

**Other Situations**

In any situation that has not been outlined in this form, unless otherwise required by law, I will request your written

authorization before using or disclosing any of your PHI. If at any time that your unsecured PHI is breached, you will be contacted immediately and appropriate measures will be taken.

**YOUR RIGHTS REGARDING YOUR PHI**

**The right to see and receive physical & electronic copies of your PHI**

This therapist is the guardian of your PHI and have the right to read, inspect, and review it at any time. You, the

client, have the right to view your records at any time. A copy can be made available for you following a written

request and a 15-day period to gather these records. I request that all clients set up a Record Review Session to

address any questions or concerns that may arise regarding your clinical records.

**The right to amend your PHI**

If you believe there is an error in your PHI or that important information has been omitted, it is your right to request

an amendment. You must make this request in writing and include a valid reason for said request. If your request is approved, I will make the necessary changes to your PHI and inform you and/or advise other parties who might need to know about amendments. If your request is denied, you will be informed in writing with reasoning and explanation for the denial.

**The right to obtain a list of the disclosures I have made**

You are entitled to a list of PHI disclosures made by submitting a request in writing. This list will include the date of disclosure, to whom and how your PHI was disclosed, a description of the information disclosed, and the reason for the disclosure. This list will not include uses or disclosures to which you have authorized or are required by law.

The right to request limits on use and disclosure of PHI

You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, though am not legally bound to agree. If I agree with your request, these boundaries and limits will be put into writing and abided by, to the extent that the law allows.

**The right to choose how your PHI is sent to you**

You may ask me to send your PHI to an alternate address or by a specific delivery method. You may also authorize in writing that your PHI be delivered to you in an electronic method. I am obligated to agree to your request providing that it does not cause undue inconvenience. If you have any questions or concerns about these privacy practices described above, please contact me immediately. Additionally, if you have any problems with how your PHI has been handled or if you believe your privacy rights have been violated, please contact directly me at 512-775-5940 or chris@itoiaustin.com. You have the right to file a complaint in writing to me. You also have the right to file a complaint with the Secretary of the Federal Department of Health and Human Services at 866-627-7748. I will not limit your care or take any actions against you due to a complaint.

By signing on page three, I the client acknowledge receipt of this Notice of Privacy Practices.

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**Tele-behavioral Health/Walk and Talk Informed Consent**

**Electronic Transmission of Information**

I, the undersigned, or my designee(s), on my behalf, agree to participate in technology-based consultation and other healthcare-related information exchanges with Chris Quaglino, LCSW, LCDC, a behavioral health care practitioner. This means that I authorize information related to my medical and behavioral health to be electronically transmitted in the form of images and data through an interactive video connection to and from the above-named practitioner, other persons involved in my health care, and the staff operating the consultation equipment.

**Meeting in Public Spaces**

I understand that meeting in public places incurs risks of being seen or heard. This is either walking and talking, or meeting at a park. I further understand that Chris Quaglino may stop a session if the work we are doing becomes emotional in nature, as not to be appropriate for an outdoor setting. I further understand that I we may run into person(s) whom may know one or both of us and we will acknowledge them if they acknowledge us first and not engage in conversation with them. And finally, I understand that the decision to participate in outdoor sessions is always optional and that I can stop any session immediately and/or request we meet inside of an office or online for any and all future sessions.

**Mobile Application**

It may also mean that my private health information may be transmitted from my practitioner’s mobile device to my own or from my device to that of my practitioner via an application or app. I understand that a variety of alternative methods of behavioral health care may be available to me, and that I may choose one or more of these at any time. My behavioral health care provider has alternatives to my satisfaction.

**Equipment**

I represent that **I will use my own equipment to communicate** during my session(s) and **not equipment owned by another**, **and specifically I will not ever use my employer’s computer or network and that I am aware that any information I enter into an employer’s computer can be considered by the courts to belong to my employer and my privacy may thus be compromised**.

**Identification**

I understand that I will be informed of the identities of all parties present during the consultation or who have access to my personal health information and of the purpose for such individuals to have such access.

**Tele-behavioral Health Process**

My health care practitioner has explained how the tele-behavioral health consultation(s) is performed and how it will be used for my treatment. My behavioral practitioner has also explained how the consultation(s) will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.

**Additional Services**

I understand that it is my duty to inform my practitioner of electronic interactions regarding my care that I may have with other health care providers.

**Electronic Presence**

In brief, I understand that my practitioner will not be physically in my presence. Instead, we will see and hear each other electronically, or that other information such as information I enter into an app will be transmitted electronically to and from myself and my practitioner.

**Limitations**

Regardless of the sophistication of today’s technology some information my practitioner would ordinarily get in in-person consultation may not be available in teleconsultation. I understand that such missing information could in some situations make it more difficult for my practitioner to understand my problems and to help me get better. My practitioner will be unable to physically touch me or to render any emergency assistance if I experience a crisis.

**Risks**

I understand that tele-behavioral health is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, possibly including some that are not yet recognized. Among the risks that are presently recognized is the possibility that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the consultation(s), and that the information will be intercepted by an unauthorized person or persons. In rare instances, security protocols could fail, causing a breach of privacy of personal health

information. I understand that a physical examination may be performed by individuals at my location at the request of the consulting practitioner.

**Release of Information**

I authorize the release of any information pertaining to me determined by my practitioner, my other health care practitioners or by my insurance carrier to be relevant to the consultation(s) or processing of insurance claims, including but not limited to my name, Social Security number, birth date, diagnosis, treatment plan and other clinical or medical record information.

**Discontinuing Care**

I understand that at any time, the consultation(s) can be discontinued either by me or by my designee or by my health care practitioners. I further understand that I do not have to answer any question that I feel is inappropriate or whose answer I do not wish persons present to hear; that any refusal to participate in the consultation(s) or use of technology will not affect my treatment and that no action will be taken against me. I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly. Were that to happen, my telehealth-based treatment might be less successful than it otherwise would

be, or it could fail entirely.

**Limits of Confidentiality**

I also understand that, under the law, and regardless of what form of communication I use in working with my practitioner, my practitioner may be required to report to the authorities information suggesting that I have engaged in behaviors that pose an imminent threat of harm to myself or will endanger others.

**Alternatives**

The alternatives to the consultation(s) have been explained to me, including their risks and benefits, as well as the risks and benefits of doing without treatment. I understand that I can still pursue in-person consultations. I understand that the tele-behavioral health consultation(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the Tele-behavioral consultations effectiveness.

**Records**

I understand that my tele-behavioral consultation(s) may be recorded and stored electronically as part of my medical records. I will be notified at the time the reason(s) for recording or storing my session(s) before this occurs. I understand that consultations, test results, and disclosures will be held in confidence subject to state and/or federal law. I understand that I am ordinarily guaranteed access to my records and that copies of records of consultation(s) are available to me on my written request. I also understand, however, that if my practitioner, in the exercise of professional judgment, concludes that providing my records to me could threaten the safety of a human being, myself or another person, he or she may rightfully decline to provide them. If such a request is made and honored, I understand that I retain sole responsibility for the confidentiality of the records released to me and that I may have to pay a reasonable fee to get a copy.

**Contact Information**

I have received a copy of my practitioner’s contact information, including his or her name and telephone.number, pager and/or voice mail number, business address, mailing address, and e-mail address (if applicable). I have also been provided with a list of local support services in case of an emergency. I am aware that my practitioner may contact the proper authorities and/or my designated, local contact person in case of an emergency.

**Emergency Care**

I acknowledge, however, that if I am facing, or if I think I may be facing, an emergency situation that could result in harm to me or to another person; I am not to seek a tele-behavioral consultation. Instead, I agree to seek care immediately through my own local health care practitioner or at the nearest hospital emergency department or by calling 911. I will also utilize the resources in the **Crisis or Emergency section** of **Tele-behavioral Health Informed Consent form.**

**Release of Liability**

I unconditionally release and discharge Chris Quaglino, LCSW, LCDC from any liability in connection with my participation in the remote consultation(s). Including Walk and Talk, as well as , Teletherapy.

**Final Agreement**

I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers. With this knowledge, I voluntarily consent to participate in the tele-behavioral consultation(s), including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms

described herein.

**Confirmation of Agreement**

By signing below, the client acknowledges the receipt of this Tele-behavioral Health Informed Consent.

**I also agree not to share the sessions I have with Chris Quaglino, LCSW, LCDC through any type of media in any format (this includes, but is not limited to, any form of social media, email, data transfer or allowing others to view my sessions in real time or recorded). I also acknowledge that Chris Quaglino, LCSW, LCDC highly recommends that I do not record my sessions so the risk of my accidental release of personal information is greatly reduced.**

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By signing on page three, I the client acknowledge receipt of this Tele-behavioral Health/Walk and Talk Informed Consent

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