

## **BEFORE YOUR FIRST APPOINTMENT**

If you choose to use your health insurance, you must call your insurance company prior to the first appointment. Please ask the following questions to the **Mental /Behavioral Health Division** representative so that all of the billing information is complete. If your claims are denied due to “no authorization,” you will be responsible for any balance due. Payment is required on your copay, and/or unmet deductible amounts, at the time of your visit.

My appointment with \_\_\_\_\_ on \_\_\_\_\_ at \_\_\_\_\_

1. Do I need an authorization for counseling sessions? Yes \_\_\_ No \_\_\_
  2. If so, what is my authorization number? \_\_\_\_\_
  3. How many sessions are allowed for this authorization? \_\_\_\_\_
  4. What is my copay amount? \_\_\_\_\_ Do I have a deductible? \_\_\_\_\_  
What is my **unmet** deductible amount? \_\_\_\_\_
  6. Are these services under an Employee Assistance Program (EAP)? \_\_\_\_\_
  7. What is the billing address for claims?
- 

Please feel free to contact our office at 740-587-5252, with any questions.

THANK YOU

**Newark-Granville Psychological & Counseling Services, Ltd.**

**Client Information**

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Sex: Male Female Social Security Number: \_\_\_\_\_

Telephone Number: Home (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Work (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

If necessary, may we call you at work if we do not identify ourselves? YES NO

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**Responsible Party**

Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

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**Primary Insurance Policy**

Insurance Company: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Insured's Social Security Number: \_\_\_\_\_

Insured's Identification Number: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Client's relationship to insured: Self: \_\_\_\_\_ Spouse: \_\_\_\_\_ Child: \_\_\_\_\_ Other: \_\_\_\_\_

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**Secondary Insurance Policy**

Insurance Company: \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Insured's Social Security Number: \_\_\_\_\_

Insured's Identification Number: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Client's relationship to insured: Self: \_\_\_\_\_ Spouse: \_\_\_\_\_ Child: \_\_\_\_\_ Other: \_\_\_\_\_

**Assignment of Benefits and Release of Information**

I authorize NGPCS to release information necessary to effect treatment and claims payment. I also authorize payment of medical benefits be made directly to the provider.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Telephone Consumer Protection Act (TCPA)**

I authorize a representative of NGPCS and/or any entity authorized by NGPCS, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided.

Email address: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent to Treat**

I agree to mental health and/or alcohol and drug treatment as offered by NGPCS for:

Myself       My Child       The person for whom I am legal guardian

I acknowledge this consent is voluntary and does not include medication/somatic (psychiatric) services.

I give consent for the use of my protected health information for treatment and payment as described in the Notice of Privacy Practices.

I further acknowledge I may revoke, in writing, this consent any time except to the extent that action based on this consent has already been taken.

Signature: \_\_\_\_\_      Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_      Date: \_\_\_\_\_

**Emergency Contact**

In case of emergency contact \_\_\_\_\_ at \_\_\_\_\_

**NEWARK-GRANVILLE PSYCHOLOGICAL AND  
COUNSELING SERVICES, LTD.  
Office and Financial Policy**

Welcome to Newark-Granville Psychological and Counseling Services, a safe place to grow. We are pleased that you have selected us to aid you to a healthier life. We want to make your visits as easy as possible by providing information that will help you with our billing and office procedures. Feel free to discuss any concerns you have with your therapist.

Please be sure to bring these items with you for each session:

Insurance Cards

Payment such as cash, check or credit card

We may not be able to see you if you do not bring these items.

If you need to cancel or reschedule an appointment, contact our office at least 24 hours in advance. You may leave a message on your therapist's confidential voice mail or with the office manager. We reserve the right to charge \$50.00 if we are not notified 24 hours in advance. If you miss an appointment without notice, a rescheduled appointment can not be guaranteed. Repeated failure to keep your appointment may result in you being dismissed as a client.

You need to be sure any authorizations for treatment are provided to us at your first visit. Your visit may be rescheduled, or you may be charged the full amount for the service if you do not provide this information.

At the time of each visit, you are responsible to pay any deductible, copayment, or outstanding balance. Payment may be made with cash, check or credit card. We accept MasterCard, Visa or Discover. There is a fee of \$32.00 for checks returned by your bank for any reason. In the case of overdue accounts, interest may be charged when the bill is delinquent. We reserve the right to turn the account over to a collection agency. You will receive notification from us prior to collection action with ample time to pay your bill. As is permitted under law, we will release your name, address, and the amount owed, should the delinquency continue.

**Are there any considerations I need to know before entering into the counseling process?**

The treatment process will be most helpful to you when you are honest and trust the process. We honor your presence and will work with you to make this a beneficial experience.

**How long does each appointment take and how long will I be in counseling?**

Appointments can be anywhere from 45 to 60-minute sessions. Your individual needs are determined by you and your therapist and will dictate the frequency of appointments and the treatment duration.

**How can I be assured that my records are confidential?**

State and Federal laws govern that your records are confidential. We release information with your signed permission. Please be aware of several rare exceptions to confidentiality. In situations of possible harm to you or another, suspected child abuse or neglect, or when a court subpoenas your records, your therapist may be required to release confidential material. You should be aware all insurance companies require a clinical diagnosis. Sometimes we have to provide additional information such as a treatment plan or summaries, or copies of the entire record (in rare instances). This information becomes part of the insurance company files. While the insurance companies do have to follow the same practices as we do regarding confidentiality, we have no control over what they do with your records. We will be glad to share with you any information released to your insurance company. Please refer to the Notice of Privacy Practices for additional information.

**What if I want to switch therapists?**

We believe that you, as a consumer, need to be comfortable with services provided. If you would like a different therapist, please discuss this in treatment. It is important that you have a therapist that meets your needs.

**How does the billing work?**

NGPCS contracts with many insurance companies. If you have insurance with one of these companies, our outside billing company, Paumier Medical Management Group, Inc.(PMMG), will submit a claim on your behalf. The initial office visit fee for psychological/counseling services is \$185; continuing appointments are \$170 for a 60 minute session, \$160 for a 45 minute family session and \$145 for a 45 minute individual session. If your insurance does not pay or partially pays, you will be responsible for the balance. Your insurance company should send you an explanation of benefits explaining to you how the claim was processed. PMMG sends out statements reflecting services and balances. All our fees are subject to change.

**What if I have an emergency that can't wait until my next appointment?**

If you call our office during regular business hours, we will try to have an available therapist respond to your needs. If there is not an available therapist, or if you have an emergency after business hours, please call 911 or the Crisis Line 345-4357 (345-HELP), or go to the nearest emergency room.

**Will I be charged for telephone calls?**

There is no charge for the initial 10 minutes of a phone call to your therapist. After 10 minutes, your charge will be prorated at our regular hourly fee. Most insurance companies do not cover telephone calls.

**Will there be any additional costs?**

Time spent on your behalf outside of counseling sessions (e.g. school consultation, court appearances, court preparations, hospitalization arrangement, etc.) result in an additional prorated billing. Routine letter writing or reports on behalf of the client will be subject to \$80/hr fee. Court related time, as outlined in "Court Related Services", constitute additional fees. **Payment is expected prior to the court appearance and/or any documents being released.** Please allow 10 business days for turn around time for reports, forms and letters written on your behalf.

**Are there special considerations if I am bringing my child for treatment?**

If the client is a minor, a custodial parent must sign a permission form authorizing services. Oftentimes the therapist will need to obtain background information from the parent to aid in the treatment process. The therapist will explain to you and your child how confidentiality works in such cases. The sessions may be divided to allow for parental consultation time. Your therapist will discuss this with you. In the case of divorce, both parents will be considered equally responsible for payment. Whoever brings the child to the office is responsible for payment at the time of the visit.

Thank you for reading this information. If you have questions about these or other matters, now or during your treatment course, please discuss them with your therapist. Dealing with these issues is often an important part of treatment. We look forward to meeting with you. If you would like a copy of these office policies for your records, please ask our Office Manager.

**I HAVE READ AND UNDERSTAND THE PRECEDING INFORMATION AND AGREE TO FOLLOW THE POLICY.**

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Signature of Client or Legal Guardian

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Date

# Newark-Granville Psychological and Counseling Services, Ltd.

## NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, that patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment, or to a collection agency if necessary.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information. **Protected health information** covers any identifiable information in the file, information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding, and certain information used for research situations. You can exercise your rights by presenting a written request to the Privacy Officer, Crystal LaPidus-Mann, LISW-S, (740) 587-5252.

You have the right to:

- Request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- Reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- Inspect and copy your protected health information.
- Amend your protected health information.
- Receive an accounting of disclosures of protected health information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Any individual or others filing a complaint will not be intimidated, coerced, threatened or discriminated against, provided the individual(s) is acting in good faith, believe the practice opposed is unlawful, and the manner of opposition is reasonable, involving the disclosure of protected health information.

Please contact us for more information:

Crystal LaPidus-Mann, LISW-S  
Privacy Officer  
Newark-Granville Psych. & Counsel.  
945 River Rd  
Granville, OH 43023-9169  
(740) 587-5252

For more information about HIPAA or to file a complaint:

The US Department of Health/Human Services  
Office of Civil Rights  
200 Independence Ave., SW  
Washington, DC 20201  
(202) 619-0257  
Toll Free: 1-877-696-6775

# NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

*Newark-Granville Psychological and Counseling Services, Ltd.*

945 River Rd, Granville, OH 43023-9169

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: \_\_\_\_\_

Client Name: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Date: \_\_\_\_\_

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## OFFICE USE ONLY

I attempted to obtain the client’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason:
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**Newark-Granville Psychological and Counseling Services, Ltd.**

## **Court Related Services**

If required to testify in court or at a deposition involving your therapy, regardless of who initiates my involvement, a non-refundable retainer of \$1500 is due within 24 hours of the subpoena being served, to block out my schedule in order to ensure my availability. If the subpoena is received without a minimum of 10 business days' advance notice, there will be an additional non refundable express charge of \$500. You will be responsible for the retainer fee whether I testify or not; further, the cause of cancellation, whether it is initiated by the court or one of the interested parties is irrelevant.

When it comes to court actions the retainer will take care of the following:

- Preparation time
- Phone calls
- Preparing and/or filing a document with the court or the party who issued the subpoena
- Mileage
- Time away from the office, including travel time, due to the subpoena and/or the inability to reschedule with clients once appointments are cleared in order to testify

The following fees are not included in the retainer fee, and will be billed after the court appearance, and are due upon receipt.

- Actual time required to give testimony or deposition: \$250 per hour
- All attorney fees and costs incurred by the therapist as a result of the legal action.
- If records are requested, an additional cost, depending on who requests the records, will be charged in accordance with the Ohio Department of Health's then effective fee schedule, in accordance with ORC §3701.741.

I understand and agree to pay the fee structure as listed above.

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Client or Guardian's Signature

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Date

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Witness

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Date

CLIENT QUESTIONNAIRE

We are pleased that you have decided to make an appointment at Newark-Granville Psychological and Counseling Services. Please complete the following with as much detail as you are comfortable. If necessary, you may attach additional sheets. The information is confidential and will save time in the early appointments.

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Marital Status \_\_\_\_\_ Who referred you to our office? \_\_\_\_\_

Please list name, relationship, and age of other household members:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

Please list all current medications, including over the counter medications and supplements:

Medication Name: \_\_\_\_\_ Dosage and frequency: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ How long used? \_\_\_\_\_

Medication Name: \_\_\_\_\_ Dosage and frequency: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ How long used? \_\_\_\_\_

Medication Name: \_\_\_\_\_ Dosage and frequency: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ How long used? \_\_\_\_\_

Medication Name: \_\_\_\_\_ Dosage and frequency: \_\_\_\_\_

Reason for medication: \_\_\_\_\_ How long used? \_\_\_\_\_

Describe the reasons for making this appointment: \_\_\_\_\_

\_\_\_\_\_

How long have you had these concerns? \_\_\_\_\_

What have you tried to help with these difficulties? \_\_\_\_\_

List recent stressful events: \_\_\_\_\_

\_\_\_\_\_

Do you have cultural, ethnic, or religious needs that may impact treatment? \_\_\_\_\_

What are your major sources of emotional support? \_\_\_\_\_

\_\_\_\_\_

How would you consider your present health? \_\_\_\_\_

What is the date of your last physical exam? \_\_\_\_\_ List any medical problems you have encountered:

\_\_\_\_\_

List any allergies, including medications: \_\_\_\_\_

List the date and type of in-patient and out-patient hospitalizations or surgeries you have experienced:

Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Date: \_\_\_\_\_ Reason: \_\_\_\_\_

Please list all substance abuse and mental health treatments:

Date: \_\_\_\_\_ Facility: \_\_\_\_\_

Reason: \_\_\_\_\_ Helpful? Yes / No

Date: \_\_\_\_\_ Facility: \_\_\_\_\_

Reason: \_\_\_\_\_ Helpful? Yes / No

Date: \_\_\_\_\_ Facility: \_\_\_\_\_

Reason: \_\_\_\_\_ Helpful? Yes / No

Please indicate your usage of the following substances:

	Date last used:	How often:
Alcohol	_____	_____
Marijuana	_____	_____
Tobacco	_____	_____
Cocaine	_____	_____
Caffeine	_____	_____
Ecstasy	_____	_____
Codeine	_____	_____
Steroids	_____	_____
Inhalants	_____	_____
Stimulants/Amphetamines	_____	_____
Sedatives	_____	_____
Opiates	_____	_____

Please check the following that apply to you:

- |  |  |
|--|--|
| <input type="checkbox"/> Numbness or tingling                              | <input type="checkbox"/> Shortness of breath                         |
| <input type="checkbox"/> Racing heart, palpitations                        | <input type="checkbox"/> Dizziness, blackouts                        |
| <input type="checkbox"/> Nausea, diarrhea, stomach pain                    | <input type="checkbox"/> Hot flashes, chills                         |
| <input type="checkbox"/> Excessive sweating, moist palms                   | <input type="checkbox"/> Feeling shaky, twitchy                      |
| <input type="checkbox"/> Headaches, body aches                             | <input type="checkbox"/> Startle easily                              |
| <input type="checkbox"/> Worry a lot                                       | <input type="checkbox"/> Road rage                                   |
| <input type="checkbox"/> Lose temper easily                                | <input type="checkbox"/> Feeling edgy, restless                      |
| <input type="checkbox"/> Difficulty concentrating                          | <input type="checkbox"/> Confusion, indecisiveness                   |
| <input type="checkbox"/> Memory problems                                   | <input type="checkbox"/> Fatigued easily                             |
| <input type="checkbox"/> Difficulty sleeping                               | <input type="checkbox"/> Sleeping too much                           |
| <input type="checkbox"/> Appetite low / high (circle the one that applies) | <input type="checkbox"/> Lost interest in usual activities           |
| <input type="checkbox"/> Feeling hopeless                                  | <input type="checkbox"/> Binge eating                                |
| <input type="checkbox"/> Excessive exercise                                | <input type="checkbox"/> Dieting                                     |
| <input type="checkbox"/> Self-induced vomiting                             | <input type="checkbox"/> Using laxatives or diuretics to lose weight |
| <input type="checkbox"/> Excessive hand washing, fear of germs             | <input type="checkbox"/> Excessive need for order or counting things |
| <input type="checkbox"/> Excessive checking (doors, locks, etc.)           | <input type="checkbox"/> Forgetful in day-to-day activities          |
| <input type="checkbox"/> Inability to throw things away                    | <input type="checkbox"/> Fidget a lot                                |
| <input type="checkbox"/> Failure to complete chores or homework            | <input type="checkbox"/> Overspending or gambling                    |
| <input type="checkbox"/> Make careless mistakes regularly                  | <input type="checkbox"/> Shame                                       |
| <input type="checkbox"/> Impulsive   |  |
| <input type="checkbox"/> Sexual problems                                   |  |
| <input type="checkbox"/> Fear of criticism or fear of being embarrassed    |  |

Age of father : \_\_\_\_\_ (If deceased, age when died and cause of death)  
Father's occupation \_\_\_\_\_

Age of mother: \_\_\_\_\_ (If deceased, age when died and cause of death)  
Mother's occupation \_\_\_\_\_

Are/were your parents divorced? \_\_\_\_\_ What age were you when they divorced? \_\_\_\_\_

Who lived in your home when you were growing up? \_\_\_\_\_  
\_\_\_\_\_

Did you have step-parents and/or a blended family? Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all of your siblings, their ages and their occupations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any medical problems, including substance abuse and psychiatric issues that run in your family:  
\_\_\_\_\_  
\_\_\_\_\_

Briefly describe major stresses in your childhood, including exposure to violence:  
\_\_\_\_\_  
\_\_\_\_\_

Do you have a history of being abused: physical, sexual, emotional or verbal? \_\_\_\_\_

List any school concerns you had as a child, including special services, repeated grades, or behavior issues: \_\_\_\_\_

Please list any marriages, and the dates of the marriages: \_\_\_\_\_

Please list any children you have and their ages: \_\_\_\_\_

If any significant others have died, please list them and the cause and date of their deaths: \_\_\_\_\_

Describe your relationship with your significant other: \_\_\_\_\_

Highest grade or degree completed: \_\_\_\_\_

Current occupation: \_\_\_\_\_ Military Service: \_\_\_\_\_

How long at your present job? \_\_\_\_\_ Describe any current work concerns: \_\_\_\_\_

Briefly describe your work history, prior to the current position: \_\_\_\_\_

Are you currently on social media? \_\_\_\_\_ How often and for how long? \_\_\_\_\_

Do you participate in online gambling or playing games? \_\_\_\_\_

Describe difficulties with friends, past or present: \_\_\_\_\_

List any legal issues you have encountered: \_\_\_\_\_

What do you consider your greatest accomplishments? \_\_\_\_\_

What do you consider your greatest disappointments? \_\_\_\_\_

What would you like to have happen as a result of participating in counseling? \_\_\_\_\_

**Thank you. We look forward to working with you.**



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*Newark-Granville Psychological and Counseling Services, Ltd.*

# CREDIT CARD PRE-AUTHORIZATION FORM

I authorize Newark-Granville Psychological & Counseling Services, Ltd to keep my signature on file and to charge the credit card selected below for the following:

- Balance remaining after claims are processed
- Recurring charge of \$\_\_\_\_\_ to be charged on \_\_\_\_\_,  
beginning \_\_\_\_\_ until paid in full. *frequency*

Visa                       MasterCard                       Discover

Client's Name: \_\_\_\_\_

Cardholder's Name: \_\_\_\_\_

Cardholder's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_ Exp Date: \_\_\_\_\_

3 digit security code on back: \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## **Newark-Granville Psychological and Counseling Services, Ltd.**

### INFORMED CONSENT ADDENDUM FOR TELEMENTAL HEALTH

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

#### What is Telemental Healthcare?

Telemental healthcare includes the practice of diagnosis, treatment, education, goal setting, accountability, referral to resources, problem solving, skills training, and help with decision making, through the use of internet-based videoconferencing or phone calls. Telehealth psychotherapy may include psychological health care delivery, consultation, coaching, and/or counseling. Telehealth psychotherapy will occur primarily through interactive audio, video, and telephone communications.

#### Risks of Telemental Health

1. Technological failure, such as unclear video, loss of sound, poor connection, or loss of connection.
2. Nonverbal cues are less readily available to both the therapist and the client.

#### Benefits of Telemental Health

1. Less limitations by geographical location.
2. Reduction of travel to a physical office, which includes decrease in travel time.
3. Participation in therapy from your own home or the environment of your choosing.

Telemental health delivery by Newark- Granville Psychological & Counseling Services, LTD may occur only with current residents of Ohio. The current laws that protect privacy and confidentiality also apply to telemental health. Any exceptions to confidentiality are described in the Informed Consent document.

All existing laws regarding client access to mental health information and copies of mental health records apply.

No permanent video or voice recordings are kept from telemental health sessions. Clients may not record or store video conference sessions or face-to-face sessions.

#### Expectations of client during each session

- 1 Minimum bandwidth connection of 384 kb or higher. (generally your phone will be sufficient)
2. Minimum resolution of 640x360 at 30 frames per second. (generally your phone will be sufficient)
- 3.Operational web camera (HD 1080p is recommended). (generally your phone will be sufficient)

4. Proper lighting and seating to ensure a clear image of each party's face.
5. Dress and environment appropriate to an in-office visit.
6. Only agreed upon participants will be present. The presence of any individuals unapproved by both parties and not part of the treatment plan will be cause for termination of the session.
7. The client must disclose the physical address of their location at the start of the session. Unknown locations will be cause for termination of the session. This is to ensure we are "meeting" at a place that will protect your confidentiality (no coffee shops, grocery stores, etc.). We may not meet while you are driving.
8. The client shall also provide a phone number where they can be reached in the event of service disruption.

Telemental health may not be the most effective form of treatment for certain individuals, or presenting presenting problems. Arrangements to meet via telehealth must be made in advance. Newark-Granville Psychological & Counseling Services, Ltd reserves the right to reject requests to meet via telehealth if the clinician does not think the situation is appropriate, or is unable to organize the technology in time to meet client request.

#### Response to technical difficulties

Should technical difficulties cause session disruption, Newark Granville Psychological and Counseling Services will contact the client via preferred telephone contact. If the technical difficulties can be resolved quickly, the session will resume and the client will not experience a shortened session length. If the technical issues cannot be resolved in a timely manner, the session will be rescheduled for a time when functionality is restored. The client will be contacted by telephone to develop a plan for continuation of the session.

#### Payment

Session costs are outlined in the Office and Financial Policy. Please refer to that document for a more detailed discussion of session cost and payment.

#### Contact between sessions

Video conference technology is reserved for therapy sessions only. Please refer to the Office and Financial Policy document for cost of contact outside of scheduled video conference sessions.

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*Client/Parent or Guardian's signature*

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*Date*

945 River Rd., Granville, OH 43023-9169  
Correspondence Address: PO Box 481, Granville OH 43023-0481  
Phone (740) 587-5252 Fax (740) 587-2571 www.ngpcs.com Email: office@ngpcs.com