

DeLuca Family Wellness Center Inc. Informed Consent and Outpatient Services Agreement

(Revised 1.1.26)

The following agreement is an overview of provider practices, expectations, and your rights and responsibilities for entering into a professional counseling relationship at DeLuca Family Wellness Center, Inc. This document is to assist you with making an informed decision about the therapeutic services being offered.

Services Provided

We provide both short and long term counseling treatment for a variety of mental and behavioral health problems including but not limited to: anxiety, depression, mood regulation, interpersonal relationships, trauma, substance abuse, conflict resolution, grief, marriage, family, parenting, and school/workplace stress.

Benefits and Risks

Benefits of Counseling Services

1. **Improved Mental and Emotional Well-Being**
Counseling supports emotional regulation, symptom reduction, and overall psychological health.
2. **Early Identification and Intervention**
Counseling can identify concerns early, reducing the likelihood of escalation or crisis.
3. **Skill Development and Coping Strategies**
Clients learn evidence-based skills for managing stress, emotions, relationships, and life challenges.
4. **Supportive and Confidential Environment**
Provides a safe, structured space to explore concerns without judgment.
5. **Enhanced Self-Awareness and Insight**
Counseling promotes understanding of thoughts, behaviors, and emotional patterns.
6. **Improved Relationships and Communication**
Supports healthier interpersonal functioning at home, work, and in the community.
7. **Promotion of Personal Responsibility and Growth**
Encourages autonomy, decision-making, and long-term personal development.

Risks and Limitations of Counseling Services

1. **Limited Effectiveness for Acute or Severe Conditions**
Counseling alone may be insufficient for individuals requiring intensive or emergency intervention.
2. **Emotional Discomfort During Treatment**
Discussing difficult experiences may temporarily increase distress.
3. **Dependence on Client Engagement**
Outcomes rely on consistent attendance, honesty, and active participation.
4. **Time to Achieve Results**
Meaningful change often occurs gradually rather than immediately.
5. **Variability in Provider Fit and Quality**
Effectiveness may be affected by therapeutic alignment, provider experience, or approach.
6. **Access Barriers**
Cost, availability, transportation, scheduling, or insurance coverage may limit participation.

I have reviewed the information on this page. (Please Initial)

Alternatives to Traditional Counseling

Alternatives to conventional services can include but are not limited to peer support groups, digital and technology-based supports, coaching and skill-based support, psychoeducation, educational workshops and faith based or spiritual support.

Consent for Treatment

I hereby request and give permission to DeLuca Family Wellness Center Inc. and its associated counselors, to provide treatment for my behavioral health concerns. I consent to the counselor performing counseling services including any therapeutic interventions they may deem reasonably necessary or desirable in the exercise of their professional judgement including those that may be unforeseen or not known at this time. The counselors therapeutic process consists of including but not limited to Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Person-Centered Therapy, Psychodynamic Therapy, and Eye Movement Desensitization and Reprocessing (EMDR) styles. I understand that if a concern is identified that is outside of the counselor's expertise, and the counselor is unable to meet my therapeutic needs, an appropriate referral will be made. I also understand that no guarantees or assurances can be made concerning the results or outcomes of any counseling services provided.

Confidentiality

Services at DeLuca Family Wellness Center, Inc. are held strictly confidential and are protected by the highest professional standards of confidentiality as specified by the Health Insurance Portability and Accountability Act (HIPAA, 1996), 21st Century Cures Act (effective April 5th, 2021), West Virginia State Law and the American Counseling Association's Code of Ethics.

When this practice examines, tests, diagnoses, treats or refers you, it will be collecting what the law calls Protected Health Information (PHI) about you. This practice needs to use this information to decide what treatment is best for you and to provide any treatment to you. This practice 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 not limited to but including court or legal purposes. This practice may use or disclose PHI for purposes outside of treatment, payment, and health care operations when appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when asked for information for purposes outside of treatment, payment and healthcare operations, an authorization will be obtained from you before releasing this information. An authorization will also need to be obtained before releasing your psychotherapy notes. "Psychotherapy notes" are notes that have been made about your conversations during private, group, joint or family counseling sessions, which have been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

By signing this form, you are agreeing to let this practice use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how this practice can use and share your information. Please read this before you sign the consent form.

If you are concerned about some of your information, you have the right to ask this practice to not use or share some of your information for treatment, payment, or administrative purposes. You will have to request what you want in writing. Although this practice will make every attempt to respect your wishes, it is not required to agree to requested limitations.

After you have signed this consent, you have the right to revoke it, in writing, and this practice will comply with your wishes about using or sharing your information from that time on considering it may already have used or shared some of your information that cannot be changed.

I have reviewed the information on this page. (Please Initial)

As mandated reporters in the State of West Virginia, we are legally obligated to violate confidentiality under the following circumstances:

1. When doing so is necessary to protect you or someone else from imminent physical and/or life-threatening harm.
2. If you lack the capacity or refuse to care for yourself and such lack of self-care presents a substantial threat to your well-being.
3. When abuse, neglect, or exploitation of a child, elder adult, or dependent adult is suspected.
4. If you pursue civil or criminal legal action against DeLuca Family Wellness Center, Inc. or any of its counselors, or if you make a complaint to a Professional Board about a counselor.
5. If you are involved in a legal proceeding and there is a court order for the release of records, or when a release is otherwise required by law.
6. Parents and guardians of minor clients have a legal right to access a minor client's records.

Client Rights and Records

HIPAA provides you with expanded rights with regard to your records and disclosures of protected health information. These rights include that we amend your record, provide you a copy of your record, requesting restrictions on what information from your record is disclosed to others, requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized, determining the location to which protected health information disclosures are sent, having any complaints you make about our policies and procedures recorded in your records, and the right to a paper copy of this agreement and privacy policies and procedures. We are available to discuss any of these rights with you.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

1. You can ask this practice to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can request this practice to telephone you at home and not at work to schedule or cancel an appointment or to have your bill sent to alternate addresses.
2. You have the right to inspect or obtain a copy (or both) of PHI in your mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Access to PHI may be denied under certain circumstances and in some cases you may have this decision reviewed.
3. If you believe the information within your record is incorrect or missing important information, you can ask this practice to make some kinds of changes (called *amending*) to your health information. Upon request, this practice will discuss with you the details of the amendment process.
4. This practice is required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.
5. This practice reserves the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, this practice is required to abide by the terms and conditions currently in effect.
6. If these policies and procedures are revised, you will be furnished with a revised written notice by mail within two weeks of revision.
7. If you are concerned that this practice has violated your privacy rights, or you disagree with a decision that has been made in regard to access to your records, you may contact Matthew J. DeLuca at 304-626-3541 for further information. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

The effective date of this notice is: January 1st, 2026. Also, you may have other rights that are granted to you by the laws of our state and these may be the same or different from the rights described above. This practice will be happy to address these situations with you.

I have reviewed the information on this page. (Please Initial)

COUNSELING AND RECORDS FOR MINORS

If you are under 18 years of age, please be aware the law provides your legal guardian(s) the right to review your treatment records as well as obtain information from us about your diagnosis, treatment and progress. It is our policy to request from your guardian(s) that they agree to avoid unnecessary review of records and involvement in your treatment with us. If they agree, we will only provide them general information about our work together, unless we feel there is a high risk that you will seriously harm yourself or someone else. In this case, we will notify them of our concern.

TECHNOLOGY PRACTICES

The DeLuca Family Wellness Center, Inc. maintains clinical documentation through an electronic health record. Intakes, as well as any other paper-generated or provided documents, will be scanned into the client's electronic file and paper copies will be securely disposed of. Safeguards with electronic record access are consistent with state and federal requirements and only authorized persons will have access to case files.

Records are kept in accordance with federal and state mandates and are retained for seven years.

Contacting DeLuca Family Wellness Center, Inc.

We are typically in the office between the hours of 8 am and 7 pm Monday through Friday. We have a voicemail service in place should you not be able to reach us directly at any time. We will make every effort to return your call on the same day you make it for non-emergency matters with the exception of weekends and holidays. Please leave us a message with your complete return contact information and we will return your message.

In some emergencies, you may need more immediate help and cannot wait for us to return your call. These emergencies might involve:

1. Suicidal thoughts of yours or a family member
2. Thoughts of hurting family members or others
3. Other dangerous behaviors by yourself or a family member

If an emergency like these, or other crises occur when we are not immediately available, you should contact one of the following 24-hour emergency lines:

- | | |
|---|------------------|
| 1. Valley Health Center in Morgantown: | 304-296-1731 |
| 2. Valley Health Center in Fairmont: | 304-366-7174 |
| 3. Chestnut Ridge Hospital Helpline: | 1-800-458-4898 |
| 4. Rape and Domestic Violence Information Center: | 304-292-5100 |
| 5. Suicide and Crisis Lifeline: | Dial or text 988 |

It is also recommended that you go to your nearest emergency room for additional assistance for these or other crises.

RECORDING

Recording a session (e.g., audio, video) or allowing a session to be recorded by a third party, either in its entirety or in part, is expressly prohibited without the express written consent of your counselor, yourself and all parties present at the time of the session.

I have reviewed the information on this page. (Please Initial)

EMAIL/TEXT MESSAGING

The use of email/texting that is not encrypted does not protect your privacy. We prefer using email/texting only to arrange or modify appointments, update demographic information or the exchange of non-therapeutic information. Please do not email/text us content related to your therapy sessions as email/text is not completely secure or confidential. If you choose to communicate with us by email/text, be aware that all emails are retained in the logs of internet service providers. This means that email content is available to be read by the system administrators of the internet service provider. You should also know that any email/text we receive from you containing therapeutic or behavioral information will become part of your legal medical record.

If you have any questions or concerns regarding any of the policies or procedures regarding electronic interaction, please bring them to our attention so that we may discuss them with you.

Legal Matters / Client Litigation

We will generally not willingly testify in any court proceeding as this role compromises and jeopardizes the therapeutic relationship. We will not be involved in any custodial disputes including testifying in any custody matters. We do not offer custody evaluations or give legal opinions or recommendations regarding custodial issues. We will generally not speak with client’s attorneys, write or sign letters, reports, declarations or affidavits. We will generally not provide testimony or records unless compelled to do so. Should we be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you agree to reimburse us for any time spent for preparation, travel or other time in which we have made ourselves available for such an appearance at our usual and customary hourly rate of \$195.00. This fee applies whether we actually testify that day or not. These fees are non-refundable and such fees are not billable to insurance and are due a minimum of one week before the scheduled court appearance.

We will provide accommodation letters for work or school. We do not provide letters for emotional support animals (ESA).

Financial and Fee Policy

PAYMENT FOR SERVICES

You are always responsible for your bill. There are payment options available: Insurance, cash, check, or credit card. In most cases, we will be able to bill your insurance company directly. However, this is a service for you and it carries no guarantee of third-party coverage. You agree to allow DeLuca Family Wellness Center, Inc. to bill your insurance(s), if available, for your care and you give direct assignment of benefits directly to DeLuca Family Wellness Center, Inc.

FEE SCHEDULE

Individual Counseling Intake/Initial Evaluation:	\$225.00
Individual Psychotherapy, 60-minute (min. 53 minute direct care):	\$210.00
Family/Couples Psychotherapy, 60-minute (min. 53 minute direct care):	\$225.00

I have reviewed the information on this page. (Please Initial)

INSURANCE

If you choose to use insurance, you are responsible for understanding your insurance coverage and for letting us know if your coverage changes. Authorization from your insurance company may be required before they will cover counseling services. If you do not obtain authorization and it was required, you may be responsible for full payment for the service.

Only your insurance company has the authority to guarantee your benefits and eligibility for coverage. You are fully responsible for any charges denied by your insurance. We strongly encourage you to contact your insurance company prior to your first appointment or at any time you feel you require clarification regarding your coverage.

If you are covered by more than one health insurance policy, you are responsible for informing us of your secondary policy. You are responsible for knowing which of your insurance policies is primary and which is secondary. If you are unclear which of your policies is primary and which is secondary, you should clarify this with your respective insurance policies.

Some insurance policies require you to provide them with scheduled updates regarding if you have obtained any additional policies since their last review and/or renew your policy with them prior to its expiration. This is commonly called "Coordination of Benefits". If you fail to provide this information to your insurance company, they may not pay for your counseling services. Should this occur, you would be responsible for full payment for your sessions.

When insurance is used for therapy services, you should be aware of the limits of confidentiality. Typically, insurance companies require your name, date of service, diagnosis and service code provided to process a claim. You are giving DeLuca Family Wellness Center, Inc. permission to disclose this, and any other information your insurance company may need to complete the processing of your claim.

MISSED APPOINTMENT/CANCELLATION/ATTENDANCE POLICY:

Regular attendance of your appointments is important to the success of your treatment. While we are sensitive to the fact that sometimes variables outside of your control may affect your daily life and schedule, 24-hour notice must be given to cancel any appointment. Should you fail to provide 24-hour notice of your cancellation or no-show your appointment, you may be charged a \$100.00 fee. Insurance does not cover missed appointments. This is standard practice and is intended to preserve time for those who may need it.

PAYMENT EXPLANATION:

You can pay your bill with us through various modalities. You may pay your balance with cash or personal check prior to each visit. Should you choose this option, we will make you aware of your amount owed prior to each session. You may put a credit/debit card on file with your balance being charged monthly either in full or an amount determined by an agreed-upon payment plan to help with large balances and/or deductibles.

If you pay for any services with a check and that transaction is returned to us from your bank for any reason, there will be a charge of \$50.00.

If you are set up for credit/debit card payments and your card declines on our monthly payment schedule, we will continue to attempt to collect as much of the balance as we can throughout the rest of the month. You are responsible for updating your card information with us to ensure that we have a working card to cover your balance.

If your account reaches an outstanding balance of \$500.00 or more and no payments have been made or received towards your account, additional counseling services will be suspended. Services will remain suspended until you begin making payments towards your account.

I have reviewed the information on this page. (Please Initial)

If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure payment. This may include, but is not limited to, hiring a collection agency, collecting through small claims court or reporting the delinquent balance to the Credit Bureau.

TERMINATION OF SERVICES

Both counselors and clients have the right to terminate therapy at their discretion. Reasons for termination can include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in therapy, client's needs are outside the scope of the counselors practice or competence, or client's not making adequate progress towards their treatment goals. DeLuca Family Wellness Center, Inc. adopts the following specific guidelines for termination of services:

1. Consistent no-show or cancellation of scheduled appointments. If there is consistent lack of commitment to attending sessions, we will terminate services and provide you a referral to another provider.
2. If, for any reason, ninety (90) days or more pass without you attending an appointment and no future appointment is scheduled, it will be assumed that you no longer wish to continue treatment and you will be discharged.

I have reviewed the information on this page. (Please Initial)

DeLuca Family Wellness Center Inc.

Acknowledgement

By signing this Informed Consent and Outpatient Services Agreement, you acknowledge that you have read, understood, and agreed to the terms and conditions contained in this form. You have been given appropriate opportunity to address any questions or request any clarification of anything unclear to you. You hereby give your consent and authorize DeLuca Family Wellness Center Inc. to evaluate, treat, and/or refer you to others as needed.

PRINTED NAME OF CLIENT:

First

Middle

Last

Signature: _____ Date: _____

PRINTED NAME OF LEGAL GUARDIAN (IF APPLICABLE):

First

Middle

Last

Legal guardian signature (if applicable): _____ Date: _____

DeLuca Family Wellness Center, Inc.
Child/Adolescent Intake

CLIENT INFORMATION AND INSURANCE:

Date: _____

1. Name: _____ 2. Birth Date: ____/____/____ 3. Sex: M F
4. Address: _____ 5. Relationship to Insurance Policy Holder:
City: _____ Self _____ Child _____
State: _____ Zip Code: _____

6. Social Security Number: _____ - _____ - _____

7. Parent/Guardian Name: _____

8. Parent/Guardian Phone: _____

9. Parent/Guardian Email: _____

10. Emergency Contact Name/Relationship/Phone #: _____

PRIMARY HEALTH INSURANCE INFORMATION:

11. Name of Policy Holder: _____ 12. Date of Birth: ____/____/____

13. Address of Policy Holder: _____ 14. Sex: M F

15. Phone number of Policy Holder: _____

16. Primary Insurance Company Name: _____

17. Member ID #: _____

18. Is there other health insurance coverage?: Yes _____ (If yes, see below) No _____

SECONDARY HEALTH INSURANCE INFORMATION:

19. Name of Policy Holder: _____ 20. Date of Birth: ____/____/____

21. Address of Policy Holder: _____ 22. Sex: M F

23. Phone number of Policy Holder: _____

24. Secondary Insurance Company Name: _____

25. Secondary Insurance Company Member ID#: _____

27. Who is legal custodian of child?: Parents _____ Other (Please specify) _____

28. If there was a divorce which state and county has jurisdiction?: _____

29. What type of legal custody was ordered?: Joint ___ Mother ___ Father ___ Other ___

Child/Adolescent Questionnaire

Client Name: _____

Name and relationship to client of person completing questionnaire: _____

What do you think are your child's main struggles? (Include current concerns and stressors).

When did you first notice these difficulties? How did these struggles come to your attention?

MENTAL HEALTH HISTORY:

Has your child been prescribed medications to manage his/her emotions or behavior? Yes _____ No _____
If "yes", please state the name of each medication, reason for taking and prescribing physician.

Has your child been in counseling before? Yes _____ No _____
If "yes", was that experience... Very positive ____ Somewhat positive ____ Negative _____ Not Sure _____
If "yes", please list the names of past therapists, reasons for treatment and dates seen.

Has your child made any suicide attempts in the past? Yes _____ No _____
Has your child engaged in any self-harm behavior (i.e. cutting or burning)? Yes _____ No _____
Has your child ever been hospitalized for mental health treatment? Yes _____ No _____
If "yes", please list name of hospital/facility, dates of stay and reason for admission.

FAMILY HISTORY:

Are the child's parents currently.... Living together ___ Married to each other ___ Separated ___ Divorced ___
Remarried ___ Widowed ___ Other ___

List the names of those currently living in your child's household. Include age, relationship to child and occupation.

Do any family members suffer from substance abuse or emotional problems? Yes ___ No ___
If "yes", please describe.

Please describe any additional family stressors that may be contributing to your child's struggles.

PHYSICAL HEALTH:

Name of Pediatrician: _____
Please describe your child's current physical health condition.

List your child's current non-psychiatric medications including name, reason for medication and name of prescribing physician.

Does your child use tobacco products? (i.e. cigarettes, snuff, vapes, etc...) Yes ___ No ___
Does your child use street drugs, painkillers, tranquilizers, stimulants or sleeping pills? Yes ___ No ___
Do you or others believe that your child has a problem with alcohol or drugs? Yes ___ No ___
Has your child received treatment for alcohol or drug abuse? Yes ___ No ___
Is your child currently facing or ever faced any criminal charges? Yes ___ No ___
Is your child currently on probation? Yes ___ No ___
If "yes" to any of the above, please explain:

SCHOOL AND SOCIAL LIFE:

Current grade level _____ Name of School _____

Has your child been diagnosed with a learning or attention disorder? Yes _____ No _____

If "yes", please describe.

Does your child currently have an IEP (Individualized Education Plan) or 504 Plan at school? Yes _____ No _____

Has your child ever been suspended or expelled from school for behavioral problems? Yes _____ No _____

Current grades _____ Typical grades _____

Describe your child's socialization (check all that apply). is popular ___ makes friends easily ___ has many friends ___
has few close friends ___ has difficulty fitting in ___
is teased or bullied ___ is shy or awkward ___
chooses friends I don't approve of ___ difficult to get to
go to school ___ underperforms at school _____

How does your child spend his/her free time? Describe any extracurricular activities and interests.

Is your child involved in any social, religious or community organizations? Yes _____ No _____

If "yes", please describe.

Please describe your child's strengths and weaknesses.

Contact Information Permissions:

I authorize DeLuca Family Wellness Center Inc to: (Please indicate YES or NO for each option)

YES _____ NO _____ Leave a message on my home telephone voicemail

YES _____ NO _____ Leave a message on my work telephone voicemail

YES _____ NO _____ Leave a message on my cell telephone voicemail

YES _____ NO _____ Leave a message with a family member/friend at my home

YES _____ NO _____ Permission to receive a reminder telephone call/text of future appointments

DeLuca Family Wellness Center, Inc.
Payment Responsibility

Name of Client: _____

Date: _____

Person responsible for payment and relationship to client: _____

Social Security Number of Person Responsible for Payment: _____ - _____ - _____

Birthdate of Person Responsible for Payment: _____ / _____ / _____

In signing, I agree to be responsible for all charges incurred during my time in counseling. I understand that it is my responsibility to educate myself and know the extent and limits of my insurance benefits. If my insurance does not pay these charges or any part thereof, I agree to be responsible and will pay the incurred fees in a timely fashion. I understand that a third party billing agency, in addition to collections agency services if necessary, may be processing my payments and these agencies are bound by a confidentiality agreement and will only have access to billing information. I agree to the assignment of benefits directly to the provider. Attached is a form for your credit/debit card information should you choose to set up an arrangement to have your payment automatically deducted. Should you choose not to set up automatic deduction, you will be responsible for payment in full, either by cash or check, prior to each visit. Visit fees are as follows: Initial session - \$225.00; Individual session - \$210.00; Family session - \$225.00.

Futhermore, I also understand that in the event I have to miss a scheduled appointment, 24-hour notice must be given or I may be charged a \$100.00 cancellation for my missed appointment.

I understand the DeLuca Family Wellness Center, Inc. makes every effort to assist in improving appointment attendance including reminder texts 24-hours prior to each appointment, however, it is my responsibility to manage my appointment times and dates. The 24-hour notice of cancellation can be achieved through telephone, fax or email. I also understand the DeLuca Family Wellness Center, Inc. may use a collection agency and credit bureau to both report and collect any balance outstanding beyond 90 days.

If you have any questions or concerns regarding any of the above, please ask prior to your therapy session beginning.

Please choose one of the following: _____ Bill my credit/debit card _____ Cash/Check in advance of session

Agreed upon monthly payment plan amount (if necessary FOR OFFICE USE ONLY): _____

Signature: _____

Date: _____

DeLuca Family Wellness Center, Inc.
Credit/Debit Card Charge Form

Date: _____

Client's Name: _____

Cardholder's Name: _____

Type of Card: Visa _____ MasterCard _____ Am Express _____ Discover _____

Card Number: _____

Expiration Date (Month / Year): _____ / _____

Three / Four Digit Security Code: _____

Cardholder's Address: Street: _____
 City: _____
 State / Zip: _____

Cardholder's Phone Number Associated with card: _____

Cardholder's Email: _____

Printed Name: _____

Signature : _____

Date: _____

DeLuca Family Wellness Center, Inc.

Telehealth Mental Health Therapy Services Agreement

Client Name: _____ Birthdate: ____/____/____

1. Telehealth mental health services are an alternative form of therapy with several limitations. There is a risk of misunderstanding one another resulting from the absence of visual or auditory cues as well as a risk of disruption to the service due to technical difficulties of the devices utilized. I understand these potential risks to using this technology and that my health care provider or I can discontinue the telehealth session if it is deemed that the conferencing connections are not adequate for the situation.
2. My health care provider has explained to me how the video conferencing technology will be used and it will not be the same as a direct client/provider visit due to the fact that I will not be in the same room as my health care provider. I have had the alternatives to a telehealth session explained to me.
3. I agree to inform my provider of my address/location at the beginning of each telehealth session. I understand that notifying my provider of my location is in my best interest in case of an emergency. This may include but is not limited to if I am having suicidal or homicidal ideations or plans, and/or intent to act out my plans; if I am in crisis that cannot be resolved remotely; or if my provider determines I need a higher level of care. I understand that in the event of an emergency, my provider may need to contact emergency services to further assess for safety.
4. There are limitations to confidentiality to be mindful of including that individuals near you may overhear your communications or have access to the platform that you are using. I understand that I am responsible for my surroundings and will make attempts to engage in telehealth sessions privately, in a quiet space and without distractions.
5. I agree to conduct myself in telehealth sessions as I would if in the office participating in a face-to-face session. This included wearing appropriate attire, refraining from substance use and not engaging in sessions while driving.
6. I understand that billing will occur from my provider and that the structure and cost of telehealth sessions are consistent with face-to-face sessions.
7. I agree that I will not record any telehealth sessions.
8. I have had a direct conversation with my provider during which I had the opportunity to ask questions in regard to telehealth sessions.

Your signature below indicates that you have read the information in this initial packet and agree to abide by its terms during our professional relationship. Your signature or the signature of your authorized person allows release of information necessary to process insurance claims and authorizes direct payment of health insurance benefits to DeLuca Family Wellness Center, Inc. THIS INFORMATION WILL INCLUDE DIAGNOSIS, DATES OF TREATMENT, AND AT TIMES, TREATMENT PLANS.

HIPAA PATIENT ACKNOWLEDGEMENT

Your signature below indicates:

1. that you have read and completed this Child/Adolescent Intake packet;
2. that you have read and agree to the Informed Consent and Outpatient Agreement
3. that you have read the Notice of Privacy Practices and agree to its terms;
4. that you have received copies of the Notice of Privacy Practices if requested;
5. that you have received a copy of the Informed Consent and Outpatient Agreement
6. that you have the right to revoke this consent, in writing, at any time by sending such written notification to this office. Your revocation will not be effective to the extent that your counselor has taken action in reliance on the authorization.
7. that you have had the opportunity to ask and have answered any questions you may have about any of the above documents.

Signature of Parent/Guardian: _____ Date: _____