2024 New Patient Forms

Welcome! Weekly sessions will benefit you the most and help you reach your goals the quickest. I am available to discuss any of your assumptions, problems, or possible side effects in our work together.

Attached are the 2024 forms for new patients to complete. Please take some time to read over these forms and understand our office policies. Each person must complete pages 2, 3, 4, 5, 6, 8, 10, 11, & 12 and send them back to me before your first session in 2024.

If you have adobe acrobat, you can use that to send me the forms. If you don't have Adobe, the best way to complete the forms is to print them, sign them, then scan them and email them back to me. You can also take a photo of each one and email them back to me. Be sure that your photos of the forms are clear and allow me to read all your responses. A typed name in a signature box counts as a signature. For security, I will request your credit card information at the start of our first session.

Therapy is effective if you make a commitment of time and energy and be an active participant. You are encouraged to ask questions, help define the focus of treatment, and discuss your progress. Therapeutic change occurs inside and outside our sessions. At times, I may give you activities and homework to augment the work we do in session.

Your session time is reserved for you. To make the most of it, please be on time. Because we have a full schedule, we must be respectful of everyone. We are very conscious of starting and ending sessions on time. If you are late, we will still finish on time. If we are late, we will extend your session. Please bring up important topics early in the session so we may give them the focus they deserve.

It's not uncommon for emotional challenges and life changes to happen because of therapy. I cannot guarantee any particular outcome from therapy. I also do not offer **emergency services;** phone calls are usually returned within 24-48 business hours.

If you need immediate assistance, text or call the National Crisis Lifeline at 988 (24/7), the Colorado Crisis Services 844-493-8255; Suicide Crisis Line 800-SUICIDE. You can also go to your nearest emergency room, or call 911 & ask for a Crisis Intervention Team Officer (CIT).

It is natural that therapy comes to an end at some point. Ending therapy can sometimes be difficult. I will discuss with you in advance if I think we need to end therapy. I ask that you discuss this with me as well. Saying goodbye is best done in a session so that we can review our work together and set aside additional time as needed.

Thank you. Chris Kalamon, LCSW

THESE FORMS MUST BE COMPLETED BEFORE YOUR FIRST SESSION

TODAY'S DATE_____

YOUR INFORMATION Print Clearly.

Name_____**Age**_____ **Birth date**_____

Street _____

City_____**Zip**_____ **Referred by** _____

Highest Education_____

Employer_____ **Job Title** _____

_____

EMAIL ADDRESS (required) Print clearly. (Used for scheduling. Do not send personal information via email)

At times, I may need to contact you.

Home Phone Number: _____ OK to call? Y N

Work Phone Number: _____ OK to call? Y N

Cell Phone Number: _____ OK to call? Y N

Best way to contact you: home work cell all numbers

Status: (circle one) S M D W LGBTQ Other_____

What are your reasons for seeking therapy? _____

_____

When did the issue first start?_____

Identify Two Goals for Therapy_____

_____

NAME _____

Medical & Psychological History Date of last physical:_____

Have you ever been in therapy before? Yes No Name and phone # or email of former therapist _____

_____

Have you ever been hospitalized for psychiatric care? Yes No If yes, please list dates & reasons:

_____

Is there a history of mental illness in your family of origin? Yes No If yes, please list who and what illness/es :

_____

Have you ever attempted suicide? Yes No If Y, please provide dates and circumstances. _____

_____

Have you been physically, mentally, or sexually abused? Yes No

Have you experienced a traumatic event? Please briefly describe the event/s and date/s. _____

_____

List all <u>current</u> medications (for medical and psychological issues):

Medication Name	Dosage	Diagnosis	Symptoms	How Long Diagnosed?

Have you experienced any of the following in the past two years? (Check all that apply)

- ❑ Frequent colds / flu
- ❑ Backaches
- ❑ Problems with vision
- ❑ Dizziness
- ❑ Headaches
- ❑ Weight loss/gain
- ❑ Irritability
- ❑ Fatigue
- ❑ Sleep problems
- ❑ Memory/concentration problems
- ❑ Thoughts about suicide
- ❑ Attempts of suicide-when? _____
- ❑ Depression
- ❑ Anxiety / nervousness
- ❑ Stomach problems
- ❑ Intrusive thoughts/sounds
- ❑ Excessive stress
- ❑ Sexual problems
- ❑ Difficulty breathing
- ❑ Problems concentrating
- ❑ Thoughts of hurting others
- ❑ Violence against others
- ❑ Chest pain

Have any of the following events occurred in your life in the past two years? (Check all that apply)

- ❑ Death of friend or family member. Who? When?_____
- ❑ Change in close personal relationship (divorce, separation, etc.)
- ❑ Serious problems with friend/family
- ❑ Personal injury, illness, accident when_____
- ❑ Family injury, illness, accident
- ❑ Major change in job status
- ❑ Serious job-related difficulties
- ❑ Accused of crime when_____
- ❑ Victim of crime when_____
- ❑ Major geographic relocation
- ❑ Sexual/physical abuse or rape. when?_____
- ❑ Sexual harassment
- ❑ Marriage
- ❑ Birth of child
- ❑ Abortion
- ❑ Miscarriage
- ❑ Surgery
- ❑ Legal problems
- ❑ Financial problems
- ❑ Gambling problems
- ❑ Other _____

Is there anything else you'd like me to know? _____

Professional Disclosure Statement

1. Master of Social Work, University of Denver (accredited Council on Social Work Education (CSWE) Program)
   Bachelor of Science, Communications & Marketing, S.I. Newhouse School of Communications (dual degree program)
   Bachelor of Arts, French Literature and Language, Syracuse University (dual degree program)
2. Licensed Clinical Social Worker – LCSW #992835. Requirements: jurisprudence exam, clinical exam by the Association of Social Work Boards (ASWB), 3360 clock hours of post-graduate work experience over 24 months, 96 clock hours of post-degree supervision over 24 months with a Licensed Clinical Social Worker. Forty professional development hours every 24-month period for continuing education and license renewal.
3. Member: National Association of Social Workers (NASW), Team Coordinator of Response Works, Boulder Psychotherapy Institute, Colorado Therapists in Private Practice, Denver Therapist Connection, Online Therapy Professionals, Peer Support Groups, Supervision to Therapists Seeking Licensure,
4. The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Social Work Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7760. 1As to the regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-master's supervision and two years of post-master's work experience. I am a Licensed Clinical Social Worker. As to the regulatory requirements applicable to mental health professionals: a Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a master's degree in their profession and have two years of post-master's supervision. A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision. A Licensed Social Worker must hold a master's degree in social work. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure. A Certified Addiction Counselor I (CAC I) must be a high school graduate, and complete required training hours and 1,000 hours of supervised experience. A CAC II must complete additional required training hours and 2,000 hours of supervised experience. A CAC III must have a bachelor's degree in behavioral health, and complete additional required training hours and 2,000 hours of supervised experience. A Licensed Addiction Counselor must have a clinical master's degree and meet the CAC III requirements. A Registered Psychotherapist is registered with the State Board of Registered Psychotherapists, is not licensed and no degree, training or experience is required.
5. Any person who alleges that a mental professional has violated the licensing laws related to the maintenance of records of a client eighteen years of age or older, must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably should have discovered this. Pursuant to law, this practice will maintain records for a period of seven years commencing on the date of termination of services or on the date of last contact with the client, whichever is later.
6. Patient Rights and Important Information: You are entitled to receive information from me about my methods of therapy, the techniques I use, the duration of your therapy, if known, and the fee structure. You can seek a second opinion from another therapist or terminate therapy at any time.
7. In a professional relationship, sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.
8. As a psychotherapist, I may consult with a variety of experts on treatment issues in a manner which protects confidentiality.
9. The information provided by and to the patient during therapy sessions is legally confidential and cannot be released without the patient's consent. There are exceptions to this confidentiality, some of which are listed in Section 12-43-218 of the Colorado Statutes and the Notice of Privacy Rights you reviewed and signed here as well as in Colorado and Federal law. Some of the circumstances where disclosure is required by the law are: reporting suspected child, dependent, or elder, abuse or neglect; and where a patient presents a danger to self or others.

   There are certain legal exceptions where disclosure may be required pursuant to a legal proceeding. If feasible, these will be identified within therapy should the situation arise. See the Private Practice Policy sheet for further information and details about confidentiality and records.

I have read this information and I understand my rights as a patient.

Date_____**Name**_____

Signature (Electronically signed by patient)_____

INFORMED CONSENT POLICY

Chris Kalamon, 303-257-7991

Welcome! Weekly sessions will benefit you the most and help you reach your goals the quickest. I am available to discuss any of your assumptions, problems, or possible side effects in our work together.

CONFIDENTIALITY. Sessions are protected as confidential under law (CRS 12,43,214 (l)(d)) with certain limitations:

- It is the law that I report **suspected** child, dependent, or elder abuse (physical, emotional, and/or sexual) or neglect, to the proper authorities who may then investigate. All that is required of me is to suspect something is wrong, not to investigate. The authorities determine if an investigation is necessary.
- If you file an official complaint or a lawsuit against me, according to Colorado law, your right to confidentiality is waived.
- Clerical persons hired by me may have access to limited confidential information. This information is protected from further disclosure and is used solely for administrative purposes.
- If you use your out-of-network insurance benefits, I cannot protect who will see it once I release the information. In addition, your insurance company may request a required summary report. This is billable time (see financial policy).
- When I am away from my office, I may ask another licensed therapist to cover emergencies for me. Generally, I will tell this therapist only what he or she needs to know for an emergency.

RECORDS. Including identifying information, types of sessions, assessment / diagnosis, treatment plan, and any consultations made. Your records will be stored safely for at least seven years as required by Colorado Statute.

- At times, your records are requested by your insurance company for various reasons. I do not release an entire record. Instead, I provide a written summary of the content related to the request. This is billable time as outlined in the Financial Policy**.**
- For family sessions, all adults present over the age of 15 will have to sign a release. You will be granted reasonable access to your record. You may request, in writing, an amendment to your record. If you choose to read your record, it is my policy to be present to respond to any questions or confusion you may have about the recordings. This is billable time.
- Private psychotherapy notes are kept separate and protected from unauthorized access. These notes are not available for review. They will be used only by your therapist and disclosure will occur only under these circumstances: (a) the therapist who wrote the notes uses them for your treatment; (b) they may be used for training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills; (c) if you bring a legal action and we have to defend ourselves; and (d) certain limited circumstances defined by the law.

AVAILABILITY. Hours for regular phone calls are 9 a.m. to 5 p.m. Mon – Thu. I will attempt to return your call within one business day. For immediate assistance or life-threatening situations, please call 911 or go to your nearest emergency room. Or call CO Crisis Services at 1-844-8255 or text them at 38255 24/7.

ENDING THERAPY. Ending therapy can sometimes be difficult. You can expect me to discuss with you if I think we need to end therapy and I also expect you to discuss this with me. In either case, the decision to end should be discussed in session and may need additional sessions to offer closure. Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

I have read the preceding information and understand my rights and responsibilities as a patient. I accept, understand and agree to abide by the contents and terms of this agreement and further consent to participate in evaluation and/or treatment.

Date_____**Name**_____

Signature (Electronically signed by patient)_____

Acknowledgement of Review of Notice of Privacy Rights - HIPAA

This Practice is required by State and Federal law to maintain the privacy of protected health information. In addition, the Practice is required by law to provide clients with access to the Notice of Privacy Practices explaining our legal duties and privacy practices with respect to your mental health information, and to request that you sign the below written acknowledgement that you reviewed a copy of this Notice. This Notice describes how the Practice may use and disclose your protected health information. This Notice also describes your rights regarding your protected health information and how you may exercise your rights. Please review the notice on the bulletin board before signing this acknowledgement. If you have any questions about this Notice or would like a copy, please contact Chris Kalamon.

I, _____, acknowledge that I reviewed a copy of the Notice of Privacy Practices
Patient Name

for Chris Kalamon, LCSW.

----------*For Practitioner Use Only*----------

I attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining acknowledgement
- ❑ Client was incapable of signing
- ❑ Other (Specify)_____

_____ _____
Signature of Practitioner Date

HIPAA - NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

The practice of Chris Kalamon, LCSW, is required by State and Federal law to maintain the privacy of protected health information. In addition, the Practice is required by law to provide clients with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to your mental health information, and to request that you sign the written acknowledgement that you reviewed a copy of this Notice. This Notice describes how the Practice may use and disclose your protected health information. This Notice also describes your rights regarding your protected health information and how you may exercise your rights.

"Protected Health Information, PHI", is information the Practice has created or received about your physical or mental health condition, the health care we provide to you, or the payment for your health care; and identifies you or could be reasonably used to identify you. It includes your identity, diagnosis, dates of service, treatment plan, and progress in treatment.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
Permissible Uses and Disclosures Not Requiring Your Written Authorization Your mental health information may be used and disclosed in the following ways.

- 256**Treatment:** Your mental health information may be used and disclosed in the provision and coordination of your healthcare. For example, this may include coordinating and managing your health care with other health care professionals. Your mental health information may be used and disclosed when I consult with another professional colleague, or if you are referred for medication, or for coverage arrangements during my absence. In any of these instances only information necessary to complete the task will be provided.
- **Payment:** Your mental health care information will be used to develop accounts receivable information, to bill you, and with your consent to provide information to your insurance company or other third party payer for services provided. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, dates and type of service, and other information about your condition and treatment, but will be limited to the least amount necessary for the purposes of the disclosure.
- **Health Care Operations:** Your mental health information may be used and disclosed in connection with our health care operations, including quality improvement activities, training programs and obtaining legal services. Only necessary information will be used or disclosed.
- **Required or Permitted by Law:** Your mental health care information may be used or disclosed when I am required or permitted to do so by law or for health care oversight. This includes, but is not limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when there is a legal duty to warn or to take action regarding imminent danger to others; (d) when the client

is a danger to self or others or gravely disabled; (e) when a coroner is investigating the client's death; or (f) to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, or regulatory compliance.

- **Contacting the Client:** You may be contacted to remind you of appointments and to tell you about treatments or other services that might be of benefit to you.
- **Crimes on the premises or observed by the provider:** Crimes that are observed by the therapist or the therapist's staff, crimes that are directed toward the therapist or the therapist's staff, or crimes that occur on the premises will be reported to law enforcement.
- **Business Associates:** Some of the functions of the practice may be provided by contracts with business associates. For example, some of the billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.
- **Involuntary Clients:** Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.
- **Family Members:** Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of the discussion. However, if the client objects, protected health information will not be disclosed.
- **Emergencies:** In life threatening emergencies the practice will disclose information necessary to avoid serious harm or death.

Uses and Disclosures Requiring Your Written Authorization or Release of Information
Except as described above, or as permitted by law, other uses and disclosures of your mental health information will be made only with your written authorization to release the information. When you sign a written authorization, you may later revoke the authorization in writing as provided by law. However, that revocation may not be effective for actions already taken under the original authorization.

Psychotherapy Notes: Psychotherapy notes are maintained separate from your mental health record. These notes will be used only by your therapist and disclosure will occur only under these circumstances: (a) the therapist who wrote the notes uses them for your treatment; or (b) they may be used for training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills; or (c) if you bring a legal action and we have to defend ourselves; and (d) certain limited circumstances defined by the law.

YOUR RIGHTS AS A CLIENT **Additional Restrictions:** You have the right to request additional restrictions on the use or disclosure of your mental health information. However, the clinician does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. Ask your clinician for the Request Form for Protected Health Information.

Alternative Means of Receiving Confidential Communications: You have the right to request that you receive communications from the practice by alternative means or at alternative locations. For example, you may request that bills and other correspondence be sent to an address other than your home address. Ask your clinician for the Request Form.

Access to Protected Health Information: You have the right to inspect and obtain a copy of your protected health information in the mental health and billing record. However, any psychotherapy notes are for the use of your therapist, and are treated differently. If it is thought that access to your mental health records would harm you, your access may be restricted. Ask your clinician for the Request Form for PHI and the appeal process.

Amendment of Your Record: You have the right to request an amendment or correction to your protected health information. If the clinician agrees that the amendment or correction is appropriate, the Practice will ensure the amendment or correction is attached to the record. An appeal process is available if the clinician determines the record is accurate and complete as is. Ask your clinician for the Request Form PHI and the appeal process available to you.

Accounting of Disclosures: You have the right to receive an accounting of certain disclosures the practice has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures authorized by you, or disclosures made prior to April 14, 2003. Other exceptions will be provided to you, should you request an accounting. Ask your clinician for the Request Form.

Right to Revoke Consent or Authorization: You have the right to revoke your consent or authorization to use or disclose your mental health information, except for action that has already taken place under your consent or authorization.

Copy of this Notice: You have a right to obtain a copy of this Notice upon request.

The Practice is required to abide by the terms of this Notice, or any amended Notice that may follow. The Practice reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that it maintains. When changes are made, the revised Notice will be posted at the Practice's office and copies will be available upon request.

If you believe the Practice has violated your privacy rights, you may file a complaint with the person designated within the Practice to receive your complaints, [*that is your clinician or the Privacy Officer*]. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Bldg., Washington, D.C. 20201. It is the policy of the Practice that there will be no retaliation for your filing of such a complaint.

CREDIT CARD AUTHORIZATION

Chris Kalamon

Everyone must have a credit card on file (VISA, MC) as a backup for late cancellations, no-show appointments, and late payments. This information is collected during your first visit, reviewed at the beginning of every year, and during the year as necessary. Health savings account cards may also be kept on file but must still have a back-up credit card in case HSA funds are depleted.

By signing below, I authorize Chris Kalamon, LCSW, to draft my credit card on file for therapy or related services including payments for Late Cancellations or No-Show fees as described in the Financial Agreement. There is a 3.55% admin fee applied to all credit card charges.

I also authorize the provider to send email or text receipts of payments made. I acknowledge that this credit card information will be kept on file via PCI-compliant encrypted code.

This authorization expires six months from the date of our final therapy session. By signing below, I confirm that I have read and understand the credit card policy.

Date_____ **Name** **(as it appears on card)** _____

Signature (Electronically signed by patient)_____

CHRIS KALAMON, LCSW

2024 FINANCIAL SERVICES AND FEES

This summary works in conjunction with our Informed Consent. Collaboration between therapist and patient will provide the greatest benefit based on your diagnosis(es) / presenting clinical concerns.

In the case of a mental health emergency, please contact 911 or the following numbers: **Colorado Crisis Services 844-493-8255; Suicide Crisis Line 800-SUICIDE.**

We raise our fees annually (usually at the beginning of the year) to allow for inflation and increased overhead costs (liability insurance, licensure requirements, mandatory trainings and CEUs).

PAYMENT by VENMO. **Please read – you may need to pay Venmo fees.** Payment is due before your session begins. You may pay by VENMO to Chris Kalamon @Chris-Kalamon. The account has my photo on it. Do not tag the payment as a purchase or a service, or our office will have to charge you the Venmo fee of $3.00 or more. This can also happen if you have a Venmo business account and pay from there. If you identify your payment as a personal payment, there are no additional fees.

CREDIT CARDS. The office will charge your credit card before your appointment if that is your preferred form of payment. All credit card charges are assessed a 3.55% admin fee. See separate credit card policy form for more information.

LATE CANCELLATION / No Show Fees. The full fee is charged if you miss an appointment or cancel with less than 24 hours' notice. This policy applies to everyone. To be fair, we must keep the fees at the same level for everyone; we can't make exceptions. For ethical and professional reasons, we do not offer discounts. You have access to the calendar 24/7 to change or cancel an appointment and avoid these fees. The calendar does not allow late cancellations; notify us by email, text or phone about these.

Standard Psychotherapy $160

Extended Therapy $210. Fees for this service are prorated every 15 minutes.

Individual Integrated Biopsychosocial Assessment First two visits, then as needed - $240 per session.

EMDR Heal from emotional distress due to disturbing life experiences. $210

Couple's Counseling. 1st session $275 / 75min. Ongoing sessions $225 / 60min**.**

Phone Calls, Telephone Management. phone calls to patients, doctors, other professionals, etc. Prorated every 15 minutes.

Emails & Texts. Emails and texts to patients, doctors, other professionals, etc. Prorated every 15 minutes.

Reports/Requests. Summary reports, attorney requests, disability paperwork, life insurance, FMLA, etc. Minimum charge of $210, then prorated every 15 minutes.

Insurance, Victim Compensation. We do not accept insurance nor have a relationship with any company. If we agree to work together, all communication with your insurance company will be between you and them.

If, for some reason, your insurance company demands communication with us, it is considered billable time payable by you. A $420 deposit (for two hours' time) is required before any communication occurs.

We also no longer accept payment from a victim compensation service for new patients. You will need to pay in full for your session then submit a claim to victim compensation for reimbursement to you.

COURT / Custody / Divorce. We will NOT testify in court concerning opinions on issues involved in any litigation, and we ask you to accept our policy. Do not use our services if you believe you will be involved in litigation. If you go to court, you will have to ask another professional to testify. If you become involved in legal proceedings that demand our participation, you will be expected to pay for all our professional time, including preparation and transportation costs, even if we are called to testify by another party. Because of the difficulty of legal involvement, we charge $400 per hour for travel, preparation, attendance and other requirements, port-to-port. A $3200 deposit is required prior to any work**.**

For more information about your right to a GFE, visit www.cms.gov/nosurprises.

My signature confirms that I understand my rights, understand that I am responsible for communicating with my insurance company on all issues, and agree to my financial responsibilities,

Date_____**Name**_____

Signature (Electronically signed by patient)_____

Telehealth Appointment Consent Form

This consent is for all telehealth services provided to me by Chris Kalamon, my Healthcare Provider. Telehealth is the use of the Internet to provide remote health care for patients. Such care may come from doctors, nurses, mental health providers, and professional health educators.

Specifically, a health care professional will be communicating with me remotely via the Internet using doxy.me web-based audio-video software {Telehealth Appointment). Doxy.me only hosts the software and does not provide medical advice or information. This Telehealth Appointment may be for diagnosis. continuity of care and treatment, testing, or medical consultation deemed necessary.

I understand that during a Telehealth Appointment:

- details of my medical history and personal health information may be discussed with me and/or other health professionals.
- audio, video, or photo recordings containing medical details may be transmitted via secure channels and those details may become part of my permanent medical record.
- all confidentiality protections granted to me by various state and federal laws also apply to my care during this appointment.
- industry-standard network and software security protocols are in place that protect the privacy of the communication and safeguard my transmitted information against eavesdropping and corruption.
- there may be security and privacy risks associated with Internet-based communications.
- there are benefits and limitations when compared to a traditional in-person visit due to the fact that I will not be in the same room as my healthcare provider.
- either my Healthcare Provider or I can discontinue the Telehealth Appointment if either of us feels that the information obtained through remote communications is not adequate *for* diagnostic decision-making or *for* providing the care I desire.
- in addition to my Provider, I will be informed of any other person(s) who may be present during the appointment and have the right to have them leave the viewing and listening area.
- to maintain my privacy, I need to ensure that my viewing and listening area is limited to myself and any other person that has a need to participate during the virtual appointment.
- due to the limitations of telehealth that are out of my control (such as an unreliable internet connection). I will call local authorities (9-1-1) to assist me with a medical emergency.
- I have the right to omit or withhold specific details of my medical history/physical examination that are personally sensitive.
- my Healthcare Provider may advise me to seek immediate treatment or determine that there is a medical emergency and, as such, local authorities may be given my personal details to assist me:
- the communication is privileged and confidential, and I will not record the audio or video without first seeking the permission of my Healthcare Provider.

Emergency Procedures specific to Telehealth Services:
I understand that if I am having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot resolve remotely, Chris Kalamon may determine that I need a higher level of care. I agree to provide an Emergency Contact Person (ECP) who she may contact on my behalf in a life-threatening emergency.

I agree to verify that my ECP is willing to come to my location in the event of an emergency. Additionally, if Chris Kalamon, my ECP or I determine that it is necessary, the ECP agrees to take me to the hospital or call the police to escort me to the hospital. My signature at the end of this form indicates that I understand all of this.

ECP Name_____ **Phone**_____
Please print

By Consenting to a Telehealth Appointment:

1. I agree to engage in remote audio-visual communication with my Healthcare Provider.
2. I understand the risks and benefits of using Internet-based communications and that no results can be guaranteed.
3. I acknowledge that if the Healthcare Provider believes that remote communication is insufficient for treatment, consultation, or evaluation, then I will be offered alternate services or options.
4. I understand that I may be responsible for co-payments, deductibles, or other charges from my Healthcare Provider, and additional charges may occur for services related to this appointment.
5. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location, or at a testing facility, at the direction of the Healthcare Provider.
6. I have the ability to ask direct questions to my Healthcare Provider about this appointment, including details about the Healthcare Provider's privacy policy.
7. If my questions are not answered to my satisfaction, I have the right to terminate the appointment.
8. I am at least 18 years of age.
9. I agree that my Healthcare Provider can contact my Emergency Contact Person (ECP) or the police on my behalf in a life-threatening emergency.
10. If the telehealth session cuts out due to any technological issues, I understand that my Healthcare Provider will call me on the phone to complete our session.

Date_____ **Name**_____

Signature (electronically signed by patient)_____

WRITE DOWN ANY ADDRESSES WHERE TELEHEALTH SESSIONS MAY TAKE PLACE:

Primary Home:_____

Secondary Home:_____

Primary Office:_____

Secondary Office:_____

Additional Addresses:_____