Center for Grief and Trauma Therapy

Child Intake Information Form

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

Your child's name: _____

Child's nickname/preferred name: _____ Child's grade in school: _____

Your relationship to child: _____

Are parents: Married? Divorced? Separated? Never married?

Is a parent deceased? □ Yes □ No If deceased please indicate which parent_____

Is your child adopted? _____ At what age? _____ Is there contact with the birth parent?_____
Age at first contact? _____ Frequency? _____

Mother's highest grade in school: _____

Current employer: _____ Position **held:** _____

History of learning or emotional difficulties? Substance abuse? (Please specify): _____

_____

Father's highest grade in school: _____

Current employer: _____ **Position held:** _____

History of learning or emotional difficulties? Substance abuse? (Please specify):

_____

If child's parents are divorced, please indicate:

Visitation schedule: _____

Child's adjustment to visitation schedule? _____

How did you hear about my services? _____

Please describe the main difficulty that has brought you to seek help for your child:

_____

Family relationship history

	Your age at marriage	When divorced/widowed	Is spouse remarried?
First	_____	_____	_____
Second	_____	_____	_____
Third	_____	_____	_____

Significant non-marital relationships of primary caregivers:

	Name of Person	Relationship to which parent?	Your child's age when it started	Problems from this relationship?
First	_____	_____	_____	_____
Second	_____	_____	_____	_____
Third	_____	_____	_____	_____

Demographics of child's current family:

Who does your child live with? _____

Relative	Name	Current Age (Or age at death)	Illness (or cause of death, if deceased)	Education level	Occupation
Stepparents	_____	_____	_____	_____	_____
Grandparents	_____	_____	_____	_____	_____
Uncles/aunts	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____

Other children in the family and their relationship to your child:

_____

Relationships in your child's family of origin. Please describe the following:

Your children's relationship with each other: _____

Your child's relationship with each parent and with other significant adults:

_____

Your child's' physical health problems, chemical use, and mental or emotional difficulties:

_____

Your relationship with your child and concerns that you might have:

_____

Abuse history:

□ My child was not abused in any way □ My child was abused

If your child was abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect you. E = Emotional, such as humiliation, etc.

Your child's age	Type of abuse	By whom?	Effects on them?	Whom did they tell?

Developmental and Medical History

Please indicate any difficulties with pregnancy and the birth of your child:

_____

Has your child experienced any developmental delays? _____

Medical History:

Starting with your child's birth and up to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions your child has.

Age	Illness/diagnosis	Treatment received	Treated by	Result

Describe any allergies your child has.

To what?	Reaction they have	Allergy medications taken

List *all* medications or drugs your child takes or has taken in the last year - prescribed, over-the-counter, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by

Has your child ever been exposed to toxic chemicals?

Date	Kinds of chemicals	Kind of work	Effects

Medical Caregivers: Your child's current family or personal physician or medical agency.

Name	Specialty	Address	Phone #	Date of last visit

If your child enters treatment with me for psychological problems, may I tell your medical doctor if needed so that he or she can be fully informed, and we can coordinate your treatment? □ Yes □ No

Please list any family history of physical health problems, chemical use, and mental or emotional difficulties:

_____

_____

_____

Are there any other medical or physical problems that you are concerned about?

_____

_____

_____

Has your child ever received psychological, psychiatric, counseling services, or had a psychological evaluation before? If so, please indicate:

When?	From whom?	For what?	With what results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your child ever taken medications for psychiatric or emotional problems? If yes, please indicate:

When?	From whom?	Which medications?	For what?	With what results?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Additional Information

Is there anything else that is important for me to know about your child, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper. If you will be participating in an evaluation, please indicate what information you hope the assessment will provide.

_____

_____

What are you most concerned about? What issues are most urgent?

_____

_____

Is there anything that I have not asked that you think I should know about your child?

_____

_____

What would you most like to achieve in considering treatment for your child?

_____

_____

Do you have any questions that you would like to discuss?

_____

_____

Please note: This is a confidential treatment record. Redisclosure is expressly prohibited by law.

Center for Grief and Trauma Therapy

5500 Skyline Drive
Suite 4
Wilmington DE 19808

Phone (302) 635-0505
Fax (302)861-3838

NOTICE of PRIVACY PRACTICES

This Notice is being provided to you by the staff at **The Center for Grief and Trauma Therapy.** All providers and staff are required by law to maintain the privacy of your Protected Health Information (PHI), including PHI that we keep in electronic form (ePHI). This Notice will help explain to you how we maintain your records, among other things. We are also required to inform you of our legal obligations and how this impacts the privacy protections for your health information.

PROTECTED HEALTH INFORMATION (PHI) is any documentation that identifies you; relates to your past, present or future mental health needs; relates to the care provided; or relates to the past, present or future payment for your care. PHI typically includes your symptoms, diagnoses, the treatment provided to you, information that may be provided about you by others who have been involved in your care, and billing and payment information relating to your care. PHI may come in traditional paper form or be kept and communicated in electronic form, referred to as ePHI. Examples of ePHI include any records we keep on the computer and/or on cloud based programs. This Notice applies to both formats.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION WITHOUT YOUR PERMISSION:

A record of your treatment is maintained confidentially. Your written permission is required to disclose any information in your record to a third party in almost all situations. Providers may use or disclose PHI/ePHI ***without*** your authorization in the following circumstances:

- **There are limits on our confidentiality when you or other persons are in physical danger:**
  - **a.** If I come to believe that you are threatening serious harm to another person, I am required to try to protect that person.
  - **b.** If you seriously threaten, or act in a way that is very likely to harm yourself, I may have to seek a hospital for you, or to call on your family members or others who can help protect you.
  - **c.** In an emergency where your life or health is in danger, and I cannot get your consent, I may give another professional some information to protect your life.
  - **d.** If I believe or suspect that you are abusing a child, an elderly person, or a disabled person I must file a report with a state agency.
  - **f.** Please bear in mind that I if you should decide to instigate any legal proceedings against me for any reason I will no longer be able to guarantee confidentiality.

- **We may occasionally consult with other health and mental health professionals** about your case. If so we make every effort to avoid revealing your identity. These professionals are legally also legally bound to keep the information confidential.
- **If you are involved in a court proceeding** and there is a request concerning the services provided you we will seek your written authorization prior to disclosing any information. If disclosure is contraindicated a court order may be needed to protect your records.
- **Should you elect to use insurance benefits** to pay for a psychological assessment or psychotherapy your insurance company has the rights to information about your diagnosis, symptoms, history and substance abuse issues (if any). We can provide no assurance that the confidentiality of your information will be maintained.
- **Joint Activities and Your Treatment:** Your PHI may be used and shared by the Providers to further their joint activities and with other individuals or organizations that engage in your treatment, payment or healthcare operational activities with the Providers. Health information is shared when necessary to provide clinical care services and to secure payment for services provided. Examples of such disclosures include letting your psychiatrist know about your response to prescribed mental health medications and communicating between Providers about shared clients, such as in family counseling.
- **To Contact You:** Your PHI may be used to call you or send you a letter about your care, for appointment reminders if you choose that service, to provide you with treatment options, or to advise you about other health-related benefits and services.
- **For Payment Purposes:** We may use your PHI/ePHI to prepare claims to your insurance company. We will include information that identifies you, as well as your diagnosis, dates and types of service provided, and any payments you have made.
- **When Required by Law:** We may use or disclose your health information when required by law. If this happens, disclosures will be made in compliance with the law and will be limited to the relevant requirements of the law. Examples include law enforcement reports, abuse and neglect reports, military command authorities, and reports to coroners and medical examiners in connection with death. The Providers must also comply with the Secretary of the Department of Health and Human Services for the purpose of investigating or determining its compliance with the requirements of the Privacy Rule.
- **For Healthcare Operations/Oversight:** The Providers may disclose your PHI to a health oversight agency, such as a government agency, for activities authorized by law, such as for professional licensure and for healthcare operations, such as seeking reimbursement from an insurance company.
- **Business Associates:** Your PHI may be used by Providers and disclosed to individuals or organizations that assist the Providers with their legal obligations as described in the Notice. For example, we may disclose information to consultants or attorneys who assist us in our business activities. Business Associates also contract with the Providers to assist in business operations, such as

billing and administrative support. These business associates are required to protect the confidentiality of your information with administrative, technical and physical safeguards.

USES AND DISCLOSURE WHEN YOU HAVE THE RIGHT TO OBJECT

- **Disclosure to and Notification of Family, Friends or Others:** Unless you object, Providers may use their professional judgment to provide relevant protected health information to your family member, friend, or another person. This person would be someone that you indicate has an active interest in your care or the payment for your mental health care or who may need to notify others about your location (for example, for transportation purposes) or general condition.
- **Clinical Notes:** Notes recorded by your Provider documenting the contents of a counseling session and your care are part of your PHI. These will not be disclosed without your consent, unless for purposes already explained herein. For example, you must authorize the release of your record to your attorney, to a life insurance company, to your employer, the military, or your school. ***You may revoke any such authorization at any time, provided the request is made in writing.***

YOUR INDIVIDUAL RIGHTS ABOUT PATIENT HEALTH INFORMATION

Your Specific Rights are listed below:

- **Right to request restrictions:** You have the right to request in writing that we not use or disclose your information for treatment, payment, and/or operational activities except when authorized by you, when required by law, or in emergency circumstances. We are not legally required to agree to your request. After you make your request to BPS, we will provide you with written notice of our decision about your request.
- **Right to request nondisclosure to health plans for services that are self-pay:** You have the right to request in writing that services for which you self-pay for in full in advance of your visit not be disclosed to your health plan.
- **Right to receive confidential communications:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a therapist. Upon your request, your therapist or this office will send your bills to another address.) To request confidential communications, you must make your request in writing to the address above and specify how or where you wish to be contacted. We will grant all reasonable requests.
- **Right to inspect and receive copies:** In most cases, you have the right to inspect and obtain copies of PHI in your therapist's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. Your Provider may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, your Provider will discuss with you the details of the request and denial process. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- **Right to request an amendment to your record:** If you believe that information in your record is incorrect or that important information is missing, you have the right to request in writing that your Provider amend your PHI for as long as the PHI is maintained in the record. In your request, you must give a reason for the amendment. We are not required to agree to your request but a copy of your request will be added to your record.
- **Right to know about disclosures:** You have the right to receive a list of instances when disclosures of your PHI have been made. Certain disclosures will not be included, such as disclosures for your treatment, billing, other healthcare operations, or when you have authorized the use or disclosure. Your first accounting of disclosures in a calendar year is free of charge. Any additional request within the same calendar year requires a processing fee.
- **Right to make complaints:** If you are concerned that we have violated your privacy, or you disagree with a decision we made about access to your records, you may file a complaint with the entity that provided the services to you. Or, you may file a complaint with **The Center for Grief and Trauma Therapy**. You will not retaliate against for filing a complaint. If you believe that your privacy rights have been violated, you may also contact the US Department of Health and Human Services, Office for Civil Rights. You can get the address of the local office from us.

Office for Civil Rights
US Department of Health and Human Services
Office of the Secretary
200 Independence Avenue,
Washington, D.C. 20201
Tel: (202) 619-0257Toll Free: 1-877-696-6775
http://www.hhs.gov/ContactUs.html

PROVIDERS' LEGAL DUTIES

We are required by law to protect the privacy of your PHI and to notify affected individuals if there is a breach in the security of your PHI. We are also required to provide you with this Notice about our privacy practices, and follow the privacy practices that are described in this Notice.

EFFECTIVE DATE AND CHANGES TO THE NOTICE

This notice will go into effect on July 24, 2019 and will continue until changes are necessary.
We reserve the right to change the privacy practices described in this Notice. We may revise or change the Notice effective for protected health information we already have as well as any information we may receive in the future. We will post a copy of the current Notice at The Center for Grief and Trauma Therapy and on the The Center for Grief and Trauma Therapy website at www.centerforgriefttherapy.com. At any time, you may download this Notice or request a copy of the Notice when you are at The Center for Grief and Trauma Therapy.

Center for Grief and Trauma Therapy

Consent for Treatment
and Limits of Liability

Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any "cures" cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances
Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency.

For cancellations made with less than 24 hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be mailed a bill directly for the full session fee.

We appreciate your help in keeping the office schedule running timely and efficiently.

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

Center for Grief and Trauma Therapy

Missed Appointment Policy

Since the scheduling of an appointment involves the reservation of time set aside especially for you, a minimum of 24 hours notice is required for rescheduling or cancellation of an appointment. If for any reason a session is canceled less than 24 hours prior, the full fee the clinician will be charged. You may also inquire whether there is an option to meet virtually if you're unable to attend an in-person session.

Our policy is after two consecutive missed appointments *in which there was no communication before or after the missed session*, we will have to close your case and you will no longer receive services with your clinician.

If you have any questions, please feel free to discuss them with your therapist or the front desk staff.

My signature indicates that I have read, understand, and agree to the Center for Grief and Trauma Therapy Missed Appointment Policy.

Print Client Name_____

Signature_____

Signature Date_____

Relationship to Client (if client is unable to sign)_____

Center for Grief and Trauma Therapy

Transformation of Grief With Compassion and Expertise

5500 Skyline Drive, Suite 4
Wilmington DE 19808
Phone: (302) 635-0505 Fax (302) 861-3838
www.centerforgrieftherapy.com

Informed Consent: Therapy

The policies and procedures of The Center for Grief and Trauma Therapy comply with applicable Delaware and California State regulations. This form is provided to give you important information regarding your legal rights and responsibilities as a client. Please ask for any clarification if you have questions and we will be happy to discuss these with you. We are committed to providing quality service, and in our practice we take steps to support the values of equal opportunity, human dignity and racial / cultural/ethnic/ gender/status diversity. If you feel that you have been inadvertently discriminated against in any way please bring this to our attention immediately.

Client Rights:

- You have the right to choose the provider and modality that best suits your needs.
- You have the right to discontinue treatment at any time for any reason, with or without notice.
- You have the right to ask any questions about the procedures used in therapy. If you wish, your clinician will explain their usual methods of practice to you.
- You have the right to learn about alternative methods of treatment, and we will gladly discuss these at your request during your treatment.
- On occasion, it may be appropriate to refer you to another therapist or related healthcare professional. Such referrals are suggestions only, and the referral does not guarantee any success about an appropriate match or treatment outcome.

Confidentiality:

According to State law, anything you tell your clinician/therapist is considered privileged information and will be held in confidence by them. Your

therapist/psychologist/clinician will not release any information to others about you unless you give them explicit permission to do so in writing. If you request that they release information about you, they will discuss any implications to you of making your records public. Please be aware, however, that there are certain situations in which they are required by law to reveal information without your permission. These are listed below:

- If your clinician comes to believe that you are threatening serious harm to another person, they are required to try to protect that person.
- If you seriously threaten, or act in a way that is very likely to harm yourself, they will have to seek a hospital for you, or call on your family members or others who can help protect you.
- In an emergency where your life or health is in danger and your clinician cannot get your consent, they may give another professional some information to protect your life.
- If your clinician believes or suspects that you, or someone else, are abusing a child, an elderly person, or a disabled person they must file a report with a state agency. This includes perpetrators who have abused people in the past who might still have access to the type of victims (e.g., children).
- Your clinician may occasionally consult with other health and mental health professionals about your case. If so, they will make every effort to avoid revealing your identity. These professionals are also legally bound to keep the information confidential.
- If you are involved in a court proceeding and there is a request for information concerning the services provided to you, your clinician will seek your written authorization prior to disclosing any information. If disclosure is contraindicated, a court order may be needed to protect your records
- Please bear in mind that if you should decide to instigate any legal proceedings against your therapist/clinician/psychologist or any other staff at The Center for Grief and Trauma Therapy, for any reason, you will forfeit your guarantee to confidentiality.
- Although The Center for Grief and Trauma Therapy does not accept in-network health insurance payments, you may request documentation to submit to your insurance company for reimbursement if your policy allows for such. In this case, your documentation will include confidential information, such as your diagnosis, dates of services, name of your clinician, and payments.

Contacting us:

Your clinician will not usually answer the phone when they are with a patient, or in a meeting. When they are unavailable please leave a message on their confidential voicemail. If you cannot wait for them to return your call, and you feel that your situation is an emergency, hang up and dial 911 immediately. You may also go to the nearest hospital emergency room and ask for the mental health professional on call. When your clinician is out of town, they will make arrangements for another qualified therapist to cover any crisis that may arise. That individual's name and contact information will be given to you. There is also an Adult Mobile Crisis Line available at (800) 652–2929.

Additional fee information re: Therapeutic services:

1. Our fee for therapy services is for 45 to 55 minute sessions, which includes the time to discuss scheduling. The fee is the same for children, adolescents and adults. Couple's and family therapy sessions may be extended to 90 minutes upon your request or if previously agreed upon when you schedule your appointment with your therapist. There is an additional fee for extended time services.
2. Your signed agreement for treatment or assessment shows commitment to pay for each therapy session at The Center for Grief and Trauma Therapy at the time of service, unless alternative arrangements have been made.
3. Your fee for therapy services depends on your practitioner and type of service. Dr. Christina Zampitella's individual sessions are $175.00. Couple's sessions are $250.00. Telehealth sessions are $150.00.
4. Services provided by licensed clinicians are $150.00 for individual sessions and $225.00 for couple's and therapy sessions.
5. Services provided by psychological assistants are $125.00 for individual sessions, $200.00 couple's sessions (60 minutes) or $300 (90 minutes), and $225.00 for family sessions.
6. Payments for group sessions are paid as a packaged service, which will vary based on the length of the sessions.
7. Payments for retreats are paid as a package and are determined based on the retreat chosen.
8. · Payments for ADHD/learning disability/psychoeducational/psychological assessments are based on requested testing. These packages and their

   details are available upon request
9. Please discuss any concerns that you might have about payment as soon as they arise.

Cancellations and missed appointments:

1. Appointment times are reserved for you, usually on an ongoing basis. If you arrive late your clinician will likely only be able to see you for the remainder of your session, as they will probably have another appointment scheduled after your appointment. If you arrive more than 20 minutes late then you may need to reschedule, as the work is

compromised by the limited time.

2. Once an appointment is scheduled, you will be expected to pay for it in full unless you provide 24 hours advanced notice of cancellation. Please understand that you will be charged for all missed appointments in full.
3. Sometimes it may be helpful to extend a session. Please note that you will be charged for sessions that are extended. A session will not be extended unless you agree

.

Other costs and fees:

1. In addition to scheduled appointments, we charge a fee for other professional services you may need. Other services include report or letter writing, telephone conversations, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other services you may request of your provider.
2. Telephone consultations with you, or on your behalf, that extend longer than ten minutes will be charged on a prorated basis. There is no charge for phone calls about appointments, or regular business matters pertaining to our sessions. **If you elect to communicate with us via e-mail or text, we will assume that you are accepting that confidentiality cannot be completely guaranteed.**
3. Signing this informed consent serves as your consent for us to use office staff to manage billing issues. They are subject to the same confidentiality agreements as we are. They have no access to any clinical or personal information, other than what is needed to bill for services.
4. If you become involved in legal proceedings that require 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.

Policies re: Treatment of a minor child:

1. Please discuss with your child's therapist how they will work with your child so that you can be informed of what to expect when you have a child in treatment.
2. Delaware and California Law authorizes the parent(s) or legal guardians to give informed consent for most medical decisions, including mental health treatment, on behalf of the minor. There are exceptions, for which minors may themselves consent. If the minor is age 14 and is mature enough to participate in therapy (per the therapist's evaluation), and the therapist's clinical judgment deems it appropriate to the situation, the minor may be seen without parental consent. However, if there is a way to include the parent(s) and family, that, of course, is the more ideal course of treatment.
3. If the parents are married or not separated, either parent acting alone may consent to mental health treatment for the minor. However, depending on the circumstances, it may be prudent to seek consent of both parents in an effort to include both parents in

the therapeutic process and to have support of both parents in the therapy with the minor. For parents who are divorced, it is critical that we receive a copy of the custody order indicating which parent has legal medical decision-making authority prior to the treatment of the minor. Report of physical custody arrangements does not fulfill this requirement. If there is joint legal custody, either parent acting alone may consent to mental health treatment, unless the joint legal custody order has language to the contrary. A step-parent does not have the authority to make mental health decisions for the child unless he or she has legally adopted the minor. A legal guardian has the same right as a parent having legal custody of a minor to consent to mental health treatment.

4. When a parent/guardian requests treatment of a minor child, it is important that the minor has confidentiality in order for therapy to have the most successful outcome. Therefore, as a parent/guardian, you are giving consent for the minor's therapy to be confidential (between their therapist and the minor).

There are exceptions to this confidentiality in the case:

1. The minor is a threat to his/herself or others;
2. Explaining any mental health diagnoses (i.e., major depression);
3. And periodic summaries of how therapy is progressing. Either you or the therapist may initiate the timing of these summaries as the parent/guardian.

Clinicians are required to intervene if:

1. The minor would present a danger of serious physical or mental health harm to self or others without the mental health treatment.
2. The minor is the alleged victim of incest or child abuse.

Cancellation policy:

Appointment times are reserved for you. Once an appointment is scheduled, you will be expected to pay for it in full unless you provide 24 hours' notice (except in unforeseen circumstances, or if you, or your child, is sick). This means that if you "no-show" for an appointment, you will need to pay for the clinician's time in full.

_____ Initial:

Appointment times are reserved for you, usually on an ongoing basis. If you arrive late, your clinician will likely only be able to see you for the remainder of your session, as they will probably have another appointment scheduled. If you arrive more than 20 minutes late, then you may need to reschedule, as the work is compromised by the limited time.

_____ Initial:

Please understand that you will be charged for all missed appointments in full if you fail to contact us.

_____ Initial:

Telephone consultations with you, or on your behalf, that extend longer than ten minutes will be charged on a prorated basis. There is no charge for phone calls about appointments, or

regular business matters pertaining to our sessions. **If you elect to communicate with us via e-mail or text we will assume that you are accepting that confidentiality cannot be completely guaranteed.**

Initial:_____

Consenting to Treatment of Minors:
In order to ensure parents/guardians consent to and have the opportunity to participate in treatment, we must understand any custody issues. Please initial the appropriate statement:

- Both parents live together and agree to this treatment Initial:_____

- There is a formal or informal custody agreement in place, and we understand that we must provide a copy of the agreement and sign a consent for treatment in joint custody cases.

  Initial:_____

- The parent/guardian signing has sole custody and will provide that paperwork.

  Initial:_____

Your signature below shows that **you have received the Informed Consent for Therapy outlining the treatment policies of our practice, a notice of your HIPAA rights, and the PATIENT FINANCIAL RESPONSIBILITY STATEMENT regarding general financial policies.**

You have also had the opportunity to ask for clarification if there is anything that you do not understand. Your signature below also indicates that you personally accept financial responsibility for the services that you receive and acknowledge that no guarantees have been made to you about your treatment outcome.

My signature indicates that I have read the policies noted above that were provided to me, and that I understand and agree to all of The Center for Grief and Trauma Therapy's Policies regarding treatment, as well as policies regarding financial arrangements for any services that I receive

Client's name:_____
(Please print)

Client's signature:_____ Date:_____

Patient/Guardian Signature:_____
Date:_____

FOR TELEMEDICINE ("TELEHEALTH") CLIENTS

Your rights:

This informed consent procedure ensures that at least all of the following information is given to you or your legal representative verbally and in writing. I understand that I have the following rights with respect to telehealth:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telehealth, including but not limited to, the possibility, despite reasonable efforts on the part of the psychotherapist, that: the transmission of my personal information could be disrupted or distorted by technical failures; the transmission of my personal information could be interrupted by unauthorized persons; and/or the electronic storage of my personal information could be accessed by unauthorized persons. In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of intervention (e.g. face-to-face services), I will be referred to a mental health professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse.

(4) I understand that I may benefit from telehealth psychotherapy, but that results cannot be guaranteed or assured. I understand that there may be issues with Wi-Fi connectivity. All attempts to keep information confidential while using these systems will be made, but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this client to use these systems for video conferencing. I will not hold this therapist liable for any gathering or use of client information by these service providers.

(5) I understand that I have a right to access my personal information and copies of case records in accordance with Delaware or California law. I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area. By signing this document, I understand that emergency situations include if I have thought about hurting or killing either another person or myself, if I have hallucinations (see or hear things others do not), if I have delusions (beliefs others may consider unrealistic), if I am in a life-threatening or emergency situation of any kind, if I am having uncontrollable emotional reactions, or if I am dysfunctional due to abusing alcohol or drugs. By signing this document, I acknowledge I have been told that if I feel suicidal, I am to call 9-1-1 or the National Suicide Hotline Toll-Free Number at 1-800-784-2433 or other local suicide hotlines.

The law requires that you sign a written statement prior to the delivery of health care via telemedicine, indicating that your or your legal representative understands the written information provided in 1 through 6 above and that this information has been discussed with me or his/her designee. _____(initial here)

If you have chosen the option to receive services via telemedicine (also known as "online, remote services" or "telehealth"), you should be aware of some specific requirements. First, all services are provided via Zoom and/or VSee, a HIPAA compliant live online meeting site. Should you decide to utilize this service, please note that while I ensure confidential meeting space on my end, you will need to ensure you have a space that is confidential wherever you choose to hold the session. By signing this agreement, you acknowledge that if you choose to have a session where another person(s) can hear you, then the breach of confidentiality is your choice and I am not held liable for such a breach. (initial here) _____

Additionally, you are consenting via written authority to allow contact with identified family and other treating professionals in your local area in case I need emergency backup, or in the case in which you are in need of services beyond the scope of telehealth practice (i.e., hospitalization).

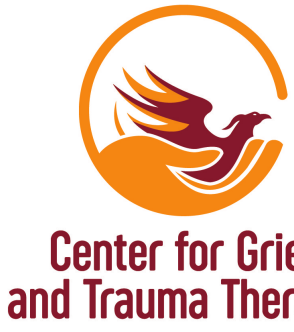
By signing below, I_____(printed name) acknowledge that I have read this informed consent and have received answers to any questions to my satisfaction.

_____

Signature of Client Date:

Signature of parent (2) Date:

Signature of parent (1) Date:



Transformation of Grief With Compassion and Expertise

5500 Skyline Drive, Suite 4
Wilmington DE 19808
Phone: (302) 635-0505 Fax (302) 861-3838
www.centerforgrieftherapy.com

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing The Center for Grief and Trauma Therapy as your Behavioral Health provider. The services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding your financial responsibility. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses, please share this policy with them, as it explains our practices regarding patient billing. By signing below and/or by receiving services from The Center for Grief and Trauma Therapy, you agree:

1. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services.
2. You will be required to follow all registration procedures, which may include updating or verifying personal information. As a self-pay patient, our fees are expected to be paid in full at the time of service.
3. Payment of any account balance is due within thirty (30) days of receipt of service. If any balance on your account is over ninety (90) days past due, your account will be in default and auto referred to the Billing Manager. Balances 90 days past due will incur a 5% increase every 30 days.
4. A. Payment by Check. If payment is made by check and it is returned or declined for any reason, your account will be charged any costs assessed or charged by any depository institution. B. Payment by Credit Card/Credit Card on File. When you pay by Credit Card to be held on file, you agree to keep the credit card information current, and you authorize The Center for Grief and Trauma Therapy to securely store your credit card information, and only charge it should you have an outstanding balance or any leftover balance from a processed claim in the future. The storage system used is fully compliant to the highest level

of credit card storage security regulations. Once stored, only the last 4 digits of your credit card are viewable by The Center for Grief and Trauma Therapy. You understand that you are responsible for all charges for services that you receive from The Center for Grief and Trauma Therapy, and if the patient responsibility portion of your charges is not paid in full within thirty (30) days following receipt of notice of these charges, and if you have a credit card authorization form on file, The Center for Grief and Trauma Therapy will bill your stored credit card for the outstanding balance due to prevent interest charges. If you have in writing that you do not want your stored credit card used then you will be provided with a statement and asked for payment. Continued treatment will be contingent on balances being paid in full after 30 days unless there is an individual written agreement that outlines other terms.

Please note: We only accept cash, debit/credit cards or certified checks for assessment services, unless other arrangements have been made. There is a 5% processing fee for credit/debit card payments for testing and assessment services.

5. Managed Care (HMO, PPO, etc.). The Center for Grief and Trauma Therapy *does not accept health insurance*. However, some insurance policies allow for out-of-network benefits. It is *your* responsibility to check your benefits with your insurance company. Insurance policies are an agreement between the patient and the insurance company, not The Center for Grief and Trauma Therapy. **Should you wish to use your out-of-network benefits, your payment for your services is still due at the time of service at the full rate of the service. The Center for Grief and Trauma Therapy will then provide you with documentation (also known as a Superbill) for you to submit to your insurance company to either be applied to your deductible or for you to be reimbursed and/orper the guidelines of your policy. How your policy works in regard to out-of-network benefits cannot be guaranteed by The Center for Grief and Trauma Therapy and The Center for Grief and Trauma Therapy will not be involved with verifying or submitting any claims on your behalf.**

6. Additional Charges. Patients may incur and are responsible for the payment of additional uncovered charges at the discretion of The Center for Grief and Trauma Therapy including but not limited to: (i) charges for returned checks; (ii) charges for a missed appointment without 24 hours advance notice; (iii) charges for extensive phone consultations and/or after-hours phone calls requiring treatment; (iv) charges for copying and distribution of patient medical records; or (v) charges for extensive forms preparation or completion. A list of potential uncovered charges is available.

15. Minor Patients. The parent/guardian of a minor is responsible for payment of the minor's account balance.

Acknowledgement

By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of the The Center for Grief and Trauma Therapy PATIENT FINANCIAL RESPONSIBILITY STATEMENT; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) to The Center for Grief and Trauma Therapy; (iv) I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

_____ _____

Patient/Responsible Party/Guardian Date of Birth

_____ _____

Signature of Patient or Guardian Date

_____

Witness/Clinician

Center for Grief and Trauma Therapy

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____ CVV: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize The Center for Grief and Trauma Therapy to charge my credit card above for services rendered (i.e., therapy sessions, testing charges, etc.). I understand that my information will be confidentially saved to file for future transactions on my account.

_____ _____

Client Signature Date