Child & Adolescent Psychological Testing & Evaluation Intake Packet

Family Guidance Centers

Office Use Only:
Therapist: _____
Dx: _____

Patient Information *(Please print and complete form in its entirety)*

Name (First, MI, Last): _____ Date of Birth: _____

Gender Identity: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Work Phone: _____

Is it okay to leave confidential information in a voicemail at the above numbers? ☐ Yes ☐ No

Email Address: _____

Do you consent to receiving appointment reminders? ☐ Yes ☐ No

How do you prefer to receive reminders? ☐ Phone ☐ Email

Employer or School Name: _____

Emergency Contact (Name/Phone/Relationship) _____

Responsible Party *(If Patient is a minor -- under 18 years of age)*

Name (First, MI, Last): _____ Date of Birth: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Work Phone: _____

Is it okay to leave confidential information in a voicemail at the above numbers? ☐ Yes ☐ No

Email Address: _____

Employer or School Name: _____

Relationship to Patient: _____

Other Parent/Guardian Name: _____

Insurance Information *(Complete this even though we will copy your insurance card)*

Insurance Company: _____ Member ID #: _____

Group #: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship to Patient: _____

Secondary Insurance Information *(Complete this even though we will copy your insurance cards)*

Insurance Company: _____ Member ID #: _____

Group #: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship to Patient: _____

I have reviewed the above information and it is true and correct to the best of my knowledge.

_____ _____ _____

Signature of Responsible Party | Print Name | Date

Family Guidance Centers

Child/Adolescent Patient History

Patient Name: _____ Therapist: _____

Name of Person Completing This Form: _____ Relationship to Patient: _____

Child's Legal Guardian Name: _____ Relationship to Patient: _____

Gender Identity: ☐ Female ☐ Male ☐ Other: _____

Name of Primary Care Physician (PCP): _____ Phone: ( ) _____

Name of Psychiatrist (If Applicable): _____ Phone: ( ) _____

Child Lives With (Select all that apply): ☐ Father ☐ Mother ☐ Siblings ☐ Foster Family ☐ Grandparents

☐ Domestic Partner/Significant Other

Parent's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Is there a current custody agreement in place? ☐ Yes ☐ No

Do you have any custody paperwork or court orders to share with your therapist? ☐ Yes ☐ No

Check any of the following that have been problematic over the last 6 months:

- ☐ Abdominal Pain - Frequent
- ☐ Allergies to Food or Medications
- ☐ ADD/ADHD
- ☐ Anger Problems
- ☐ Anxiety
- ☐ Bed Wetting (after age 5)
- ☐ Cancer
- ☐ Concentration Problems
- ☐ Depression
- ☐ Dizziness/Fainting
- ☐ Eating Problems
- ☐ Educational Problems
- ☐ Epilepsy
- ☐ Excessive Energy
- ☐ Excessive Worrying
- ☐ Extreme Fears
- ☐ Fatigue
- ☐ Gender Identity
- ☐ Headaches
- ☐ Heart
- ☐ Lack of Energy
- ☐ Lack of Motivation
- ☐ Lack of Self-Control
- ☐ Loneliness
- ☐ Loss of Family Member
- ☐ Muscle/Joint
- ☐ Nightmares
- ☐ Overtiredness
- ☐ Panic Attacks
- ☐ Physical Assault
- ☐ Separation/Divorce
- ☐ Sexual Assault
- ☐ Shyness
- ☐ Sleep Problems
- ☐ Suicidal Thoughts
- ☐ Unhappiness
- ☐ Weight Issues
- ☐ Other _____

_____

_____

_____

Has your child had major illnesses/surgeries/injuries/hospitalizations ☐ No ☐ Yes, list incident and date(s):

_____

_____

Does your child have any medical issues? Currently or historically? ☐ No ☐ Yes, please describe:_

_____

_____

Has your child previously received any type of mental health services (therapy, psychiatric care, etc)? ☐ No ☐ Yes

_____

_____

Has your child previously received any type of mental health services (therapy, psychiatric care, etc)? ☐ No ☐ Yes

_____

_____

Has your child ever been hospitalized for psychiatric reasons? ☐ No ☐ Yes, list incident and date(s):_____

_____

_____

Has your child ever attempted suicide? ☐ No ☐ Yes, list incident and date(s):____

_____

_____

Has your child ever engaged in self-harming behaviors? ☐ No ☐ Yes, please describe:___

_____

_____

Is your child currently taking any prescribed medications? ☐ No ☐ Yes, please list medication and dosage:

_____

_____

Has your child ever been prescribed psychiatric medication? ☐ No ☐ Yes, please list medication and include dates:

_____

_____

General Health & Mental Health Information:

1. How would you rate your child's current physical health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific health problems your child is currently experiencing: _____

_____

2. How would you rate your child's current sleeping habits:

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Please list any specific sleep problems your child is currently experiencing: _____

_____

3. How many times per week does your child generally exercise: _____

   What types of exercise does your child participate in: _____

4. Please list any difficulties your child may experience with appetite or eating patterns: _____

_____

5. Is your child currently experiencing overwhelming sadness, grief, or depression? ☐ No ☐ Yes, if so, for approx. how long? _____
6. Is your child currently experiencing anxiety, panic attacks, or have any phobias? ☐ No ☐ Yes, if so, when did they begin experiencing this? _____
7. Has your child engaged in any alcohol or drug use to your knowledge? ☐ No ☐ Yes ☐ Unsure

   _____

8. How often does your child exhibit temper tantrums or behavioral issues? ☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never Describe: _____
9. Is your child currently in a romantic relationship? ☐ No ☐ Yes ☐ Unsure
10. What significant life changes or stressful events has your child experienced recently:

_____

_____

Family Mental Health History:

1. Have any family members participated in counseling?:

☐ Mother ☐ Father ☐ Sisters ☐ Brothers ☐ Grandparents

2. Have any immediate family members experienced the following? Check all that apply.

☐ Alcohol/Substance Abuse ☐ Anxiety ☐ Depression ☐ Domestic Violence ☐ Eating Disorders ☐ Obesity

☐ Obsessive Compulsive Disorder ☐ Schizophrenia ☐ Suicide Attempts

Does your family have any additional psychiatric history? ☐ No ☐ Yes, please describe:__

_____

3. Who is your child's current support system?

_____

_____

Additional Information:

1. How would you rate the current stress level in the family home?

☐ Very Stressful ☐ Stressful ☐ Neutral ☐ Stress-free

If stressful, what contributes mostly to the stress? _____

_____

In the past year, have there been any changes in your family? ☐ Birth ☐ Change to a New School ☐ Death

☐ Divorce ☐ Loss of Job ☐ Marriage ☐ Move to a New Neighborhood ☐ Separation ☐ Serious Illness

Other Changes/Stressors _____

2. School Information:

Name of School: _____ Grade: _____

How would you rate your child's school performance?

Academic (Grades in School): ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Behavior in School: ☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

Has your child ever repeated or skipped a grade? ☐ No ☐ Yes, please describe:

_____

Does your child receive any special services at school such as an IEP, special education, or speech or language therapy services? ☐ No ☐ Yes, please describe:

_____

_____

3. Is your child currently employed? ☐ No ☐ Yes

   If yes, what is your child's current employment situation and for whom do they work?

   _____

   Has your child ever been fired from a job? ☐ No ☐ Yes, please describe why:

   _____

   _____

4. Is your family spiritual or religious? ☐ No ☐ Yes, if so, describe your faith or belief:

   _____

5. Are there any cultural considerations you would like for us to consider in your care? ☐ No ☐ Yes, please explain:

   _____

6. What would you like your child to accomplish out of their time in therapy?

   _____

   _____

7. What additional information would you like your therapist to know about your child?

   _____

   _____

Family Guidance Centers

Consent for Treatment *(Please complete section A or B and sign below as indicated)*

A. I, _____ (patient name), the undersigned, do voluntarily consent to behavioral health assessment and/or treatment for myself by a Family Guidance Centers therapist.

B. I, _____ (parent/guardian name), the undersigned, am the legal guardian of _____ (child's name), _____ (date of birth), a minor child. I do voluntarily consent to their behavioral health assessment and/or treatment for myself by a Family Guidance Centers therapist.

- I understand that like other healing arts, behavioral health is not an exact science and no guarantees are being made as to the results of assessment and/or treatment.
- I am aware that I am an active participant in this endeavor and that I share the responsibility for the treatment process
- I understand that assessment and/or treatment will be kept confidential with the exception of legal limitations of confidentiality. In addition, I am aware that although your therapist is clinically independent, consultations with other therapists are sometimes advisable, and my signature below gives your therapist permission to do that. I further understand that there are specific and limited exceptions to this confidentiality which include the following:
    - When there is risk of immediate danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
    - When there is suspicion that a child or elder is being abused or is at risk of such abuse, the clinician is legally required by Virginia State to take steps to protect the child, and to inform the proper authorities.
    - When a valid court order is issued for medical records, the clinician and agency are bound by law to comply with such requests
- I understand that when the above named therapist is unavailable, another behavioral health provider may be providing crisis coverage. I understand that the therapist providing coverage may be given access to relevant information in order to provide the best interim care possible.
- I authorize the release of any information necessary to process any insurance claims. This would include an ongoing release of information to meet managed care review requirements.
- If you are a member of a Managed Care Organization, a "Members Rights and Responsibilities" document may be available to you.
- FGC has provided me with the opportunity to read the Notice of Privacy and all of my questions have been answered.
- You have the right to revoke this consent in writing and terminate services with the above named therapist at any time. In that event, your therapist or FGC staff is willing to help you locate alternative resources in the community.

I have read and understand the information on this form. My signature indicates my informed consent with your therapist. If you have any questions about the form, please discuss them with your therapist.

_____	_____	_____
Signature of Responsible Party	Print Name	Date

In order to provide the best possible care, your therapist would like to be able to communicate with your Primary Care Physician (PCP). Many insurance companies require this information.

Please check one of the following: ☐ **I DO** or ☐ **I DO NOT** give FGC permission to exchange my protected health information or my child's protected health information with our PCP.

_____	_____	_____
Signature of Responsible Party	Print Name	Date

Family Guidance Centers

Notice of Privacy Receipt and Acknowledgement of Notice

Patient Name: _____

Date of Birth (MM/DD/YY): _____/_____/_____ SSN: _____

I hereby acknowledge that I have received and have been given the opportunity to read a copy of Family Guidance Center's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact my Family Guidance Center therapist.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent, Guardian or Personal Representative* Date

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual- power of attorney, healthcare surrogate, etc.

Patient **Refuses** to acknowledge Receipt: _____

_____ _____

Signature of Staff Member Date

PATIENT RIGHTS are posted in the waiting room. Copies are available upon request.

Family Guidance Centers

Financial Procedures and Agreement

In order to help eliminate any misunderstandings with regards to your financial responsibilities, the following policies and procedures will be adhered to.

Psychological Services and Costs

Service	Fee Schedule	Self Pay Rates (Master Level Clinicians)	Self Pay Rates (Psychologists)
Initial Diagnostic Interview (90791)	$200	$135	$160
60 Minute Therapy Session (90837)	$175	$115	$135
45 Minute Therapy Session (90834)	$160	$100	$115
30 Minute Therapy Session (90832)	$120	$55	$75
Family W/O Patient (90846)	$160	$115	$135
Family with Patient (90847)	$160	$115	$135
Psychological Testing (per hour)	$175	N/A	$175

These charges remain the same whether the treatment is on an individual, couple, or family basis. The psychological testing process and time required varies with the issues/problems to be evaluated, the type of testing instruments to be used and the time required by the psychologist to score and complete a report of the findings. For more information on psychological testing, please visit our website.

_____*(initial here)* **Financial Policies and Cost of Services**

Most insurance companies reimburse a portion of the cost of services. We will assist you as best we can to determine your copay, deductible, or coinsurance amounts and we will automatically file your claim, if accurate and current insurance information is provided. Each responsible party is required to complete the patient information form with accurate and complete information. Failure to provide current and accurate information may result in reimbursement denial by your insurance company. As a service to our clients, we will assist you in completing and filing the insurance claims. Further, a monthly statement will be sent to the address on file for accounts with balances above $5. Most insurance plans call for a deductible or co-payment then will typically pay a percentage of the costs thereafter. EACH CLIENT IS REQUIRED TO FULFILL THE DEDUCTIBLE AND THEN PAY THE REMAINING PERCENTAGE OR COPAY ON A SESSION BY SESSION BASIS. ANY OTHER ARRANGEMENTS MUST BE NEGOTIATED AT THE TIME TREATMENT HAS BEGUN, AND MUST BE IN WRITING. Otherwise, FGC will hold you responsible for professional services rendered at our above noted self pay rates. Please note, however, that you are responsible for verifying your insurance benefits, providing any required background or other information to the company prior to payment, and arranging for initial preauthorization of care, if required. Ultimately, you are responsible for your bill, not your insurance company.

_____ *(initial here)* **Records Release, Preparation of Letters or Reports, Non-Emergency Telephone Calls, and other Incidental Activities**

In recent years, healthcare companies have reduced reimbursement rates and limited coverage to face-to-face contact only. Records releases, reports, letters, disability certificates, telephone calls, and many other necessary activities are not covered by your insurance. Charges for these services are calculated based on the time required to complete the activity as shown in the fee schedule below.

_____ *(initial here)* **Court Related Activities**

Court and forensic activities are an additional out of pocket cost that is not covered by your insurance. As a general policy, our therapists cannot be available "on-call". **A required retainer of $1,500 is due at least 72 hours before the scheduled court appearance. This is non-refundable. Our fees are listed below.**The remainder of the costs will be billed after the court appearance and will be due upon receipt.

_____ *(initial here)* **Cancellation & No Show Policy**

A minimum of **24 hours notice is required for cancellation of appointments**. If this notice is not received or if the patient fails to show for the appointment, the Responsible Party will be charged $100 for the no show/late cancel appointment. No show or late cancel appointment fees are due immediately. Such charges will not be billed to the insurance company. Therapists may elect to terminate treatment for failure to attend scheduled appointments.

_____ *(initial here)* **Delinquent Accounts**

Every effort will be made to obtain reimbursement through your insurance plan if they are services covered by your insurance. However, it remains your full legal responsibility to assume the financial obligations for our bill should the insurance company deny any part of the claims for services rendered. Accounts are considered past due if no payments have been made for 30 days. Statement of charges sent to you are agreed to be correct and reasonable unless disputed in writing within 30 days. After a 90 day absence of payment, the account is delinquent and will be forwarded to collections. Should it be necessary to resort to a collection agency and/or attorney for the collection of your account, you agree to pay any attorney and collection fees not to exceed 1/3 of the unpaid balance and any court costs incurred in addition to the amount owed.

Services Not Covered by Insurance

Service	Fee Schedule
Preparation of **non-forensic** reports, letters, telephone or other conferences (including all patient or Responsible Party requested telephone contact), chart review, records releases per half hour*	$40
Court - preparatory time (including submission of records), phone calls, email or written letters, time away from office due to depositions or testimony Per Hour*	$220
Court - Depositions and Time Required Giving Testimony Per Hour*	$250
Court - Mileage	$0.58/mile
Court - Filing a document with the court	$100 Plus Court Fees
Court - Express Charge (If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice there will be an additional $250 “express” charge	$250
Court - If the case is reset with notice of less than 72 business-hours, the client will be charged $500 (in addition to the retainer of $1,500)	$500
Court - A required retainer of $1,500 is due at least 72 hours before the scheduled court appearance. The remainder of the costs will be billed after the court appearance and will be due upon receipt.	$1,500 minimum
No Show or Late Cancellation Appointment Fee*	$100

(*These services are not covered by insurance)

I have read and agree to financial responsibilities for entering into counseling with FGC. Your signature below authorizes release of medical information necessary to file your insurance claim(s) and assign benefits to FGC. In the event that a legal collection action is necessary, you authorize FGC or its agent to make a credit investigation, including employment verification.

_____ _____ _____

Signature of Responsible Party Print Name Date

Family Guidance Centers

Psychological Testing & Evaluation Agreement

This agreement is an addendum to the Financial Procedures and Agreement form and is part of the Intake Packet for FGC services.

Psychological Testing and Evaluation (PTE) is a complicated and time consuming process. A full PTE can, on average, range between 8 to 14 hours and depends on the areas of need. Additional hours may be required and will be decided upon by the individual Psychologist. These total fees may be less in a tightly-focused assessment in which fewer tests are administered; they can be more in very complicated cases in which many assessment procedures are needed. A full PTE includes: a review of medical and/or school records, relevant consultations with treating professionals, actual testing administration, test scoring and interpretation of data, and report writing. A part of this process is an initial diagnostic interview and a final results review session. All PTEs are unique and sometimes require additional tests beyond the usual protocols. In most cases, a final written report can be provided within 4 weeks after completion of the PTE. Please note, no specific guarantees are made about the results/recommendations of the evaluation (including diagnoses) or the number of sessions necessary for the PTE to be completed.

For self pay patients, a $525 partial payment must be paid at the initial testing session. All future testing appointment fees are due and payable at the time services are rendered. The fee for each service noted above is $175/hour. A credit card on file and authorization form is required for PTE services. Please be advised that any legal or court consultation, witness, or appearance is billed at $175/hour with a 2 hour court appearance minimum ($350) to be paid in advance of the court date. No PTE report is released until the account balance is paid in full via cash or credit card. Failure to give proper 24 hour cancellation notice may result in a $100 charge. It may also jeopardize the ability to schedule any future PTE appointments. Insurance is accepted for the PTE services for the certain insurance providers. Please check with the front office staff to see if your insurance is accepted. Insurance coverage may still require a patient responsibility portion, which will be due upon the start of each session.

I have read and understand the information on the PTE services and fees.

_____
Printed Name

_____ _____
Signature Date

_____ _____
Parent/Guardian Signature Date

Psychological Testing & Evaluations Credit/Debit Card Payment Authorization Form

I authorize Family Guidance Centers to initiate charges to my Credit/Debit Card listed below for the total amount due at each psychological testing visit. Charges to my account may vary. 24 hours notice is required for cancellation. Failure to attend a scheduled psychological testing visit can result in a $100 fee which you authorize to be automatically charged by way of this form. Please discuss any no show charges with your therapist.

If necessary, I authorize Family Guidance Centers to initiate adjustment for any transactions credited or debited in error. This authority will remain in effect until Family Guidance Centers has received written notification from myself to cancel it, allowing 30 days for action on my cancellation notice.

Patient Name: _____ Patient DOB: _____ /_____ /_____

Parent/Guardian Name: _____ Parent DOB: _____ /_____ /_____

Phone Number: _____ Email: _____

_____ _____

Signature Date

Credit Card Information
Card Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____/_____
CVV2 (3 digit number on back of card): _____
Cardholder ZIP Code (from credit card billing address): _____

_____ _____

Cardholder Signature Date

Family Guidance Centers

Release of Information Authorization

_____ I do not wish to release information to anyone but myself

Client Name: _____ Client DOB: _____ /_____ /_____

Parent/Guardian Name: _____ Parent DOB: _____ /_____ /_____

Client authorizes Family Guidance Centers to disclose the selected information to the following people:

1. Name: _____ Phone: _____ Relationship: _____
2. Name: _____ Phone: _____ Relationship: _____
3. Name: _____ Phone: _____ Relationship: _____

DESCRIPTION OF INFORMATION TO BE DISCLOSED
Please initial each item that you allow to be disclosed.

_____ Assessment

_____ Diagnosis

_____ Psychological Evaluation

_____ Progress in Treatment

_____ Current Treatment Update

_____ Other _____

_____ Presence/Participation in Treatment to include appointment dates and times.

REVOCATION: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Family Guidance Centers' Administration at contact@familyguidancecenters.com. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.
EXPIRATION: Unless sooner revoked, this authorization does not expire.
FORM OF DISCLOSURE: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner we deem appropriate and consistent with applicable law and our Privacy Policy, including, but not limited to, verbally, in paper format, and electronically.
REDISCLOSURE: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be re-disclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

_____ _____
Client or Parent/Guardian Signature Date

_____ _____
Clinician/Witness Date

Family Guidance Centers

Phone & Email Contact Consent and Authorization

I, _____ , with respect to any services provided or that are planned to be provided to myself or, as an authorized legal representative, for the below listed individual, fully consent to and authorize Family Guidance Centers staff and therapists or any of its automated systems to contact me via phone or email address (including to my cellular phone by way of phone call, or text message) in relation to any services received from Healthcare Provider or any services planned to be received from Healthcare Provider (including any billing items or appointment reminders).

As a patient of Family Guidance Centers, you may request that we communicate with you via unencrypted electronic mail (email). This page will inform you of the risks of communicating with your healthcare provider via email. Your health is important to us and we will make every effort to reasonably comply with your request to receive communications via email, however, we reserve the right to deny any request for email communications when it is determined that granting such a request would not be in your best interest.

Family Guidance Centers will make every effort to promptly respond to your requests for information via email, however, *if you are experiencing an emergency, you should never rely on email communications and should seek immediate medical attention*.

Risks of using email to send protected health information include, but are not limited, to:

- **Risk of Unauthorized Access by a 3rd Party**: Do you share a computer with your family? Is your email address or access to email provided through your employer? Do you access your email over an unsecured connection such as public Wi-Fi? Do you access your email on your mobile device? Emails may be accessed by someone you do not wish to know about your health information. Despite necessary precautions, email may be sent to the wrong address by either party. Email may be intercepted or altered in transmission by a computer hacker or computer virus.
- **Unique Difficulty in Verifying the Sender**: Email may be easier to forge than handwritten or signed papers. Family Guidance Centers will only send emails to the email address you provide, but it may be difficult to confirm that you are in fact the person sending the request for information from your email address.

Patient Consent to Unencrypted Email Communications

By signing below, you acknowledge your recognition and understanding of the inherent risks of communicating your health information via unencrypted email and hereby consent to receive such communications despite those risks. Messages containing clinically relevant information may be incorporated into the medical record at the provider's discretion.

By signing below, you also acknowledge that you have the choice to receive communications via other more secure means such as by telephone. By signing below, you agree to hold Family Guidance Centers harmless for unauthorized use, disclosure, or access of your protected health information sent to the email address you provide.

If this Consent and Authorization *applies to someone for whom you are a legal representative, **please print their name below**, if not please indicate so by populating the blank with N/A*.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent, Guardian or Personal Representative* Date

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual power of attorney, healthcare surrogate, etc.

Family Guidance Centers

Telehealth Consent Form

Patient Name: _____ DOB: _____ / _____ / _____

1. I understand that my therapist wishes me to engage in a telemedicine therapy visit.
2. My therapist has explained to me how the video conferencing technology will be used and how it will not be the same as a direct patient/therapist visit.
3. I understand there are potential flaws to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my therapist or I can discontinue the telemedicine therapy visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I agree not to operate a motor vehicle during the duration of my telehealth therapy visit.
5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. The information shared will only be on a need to know basis explicitly for billing and scheduling.
6. I have had the alternatives to a telemedicine therapy explained to me, and am choosing to participate in a telemedicine therapy visit.
7. I understand that billing will occur from my therapist under the facility of Family Guidance Centers.
8. I have had a direct conversation with my therapist, during which I had the opportunity to ask questions in regard to this telemedicine therapy visit. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me.
9. I understand that I may only participate in telehealth sessions while physically located in the state of Virginia, where my therapist is licensed.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Patient or Parent/Guardian Signature Date

_____

Parent/Guardian Name