CHILD INTAKE FORM

Child's Name: _____ Age: _____ Date of Birth: _____ Date: _____

Sex: ☐ Male ☐ Female ☐ _____ Your name and relationship to child: _____

Who has current legal guardianship of child: _____

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Hispanic/Latino

☐ Native Hawaiian/Pacific Islander ☐ Alaskan/Native American Tribe: _____

Cell #: _____ Home #: _____ Work #: _____

Physical Address: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____ County of Residence: _____

Who referred this child to Lake Country Associates? _____

Child currently Lives:

☐ at home with family (Names of Parents): _____

☐ at a relative's home (Name and Relationship of custodial adults in this home): _____

☐ in a foster home (Name of foster parents): _____

☐ at a group home or residential facility (Name of Facility): _____

☐ other (please explain): _____

Length of time child has been at current placement? _____

People residing in the same household with child:

Name	Age	Occupation	Relationship to child

Health Current physician: _____ Location: _____

When was your child's last physical examination? _____ Results: _____

Is your child allergic to any drugs? ☐ Yes ☐ No If yes, please list: _____

School Current School/Childcare: _____ Grade: _____

School Contact: _____

In case of emergency, who may we contact? *

Name Relationship to Child Phone Number

Initial: _____ **I authorize Lake Country Associates, Inc. to release necessary information to my emergency contact in the event of emergency*.

Child's Name: _____Date: _____ **CHILD ADDITIONAL INFORMATION**

Welcome to Lake Country Associates

This form is meant to provide your therapist information to help in providing thorough and relevant therapy services, as well as to make the best use of the initial intake session.

Main concerns for which services are being sought:
Goals you hope to achieve by coming for services:

How much are each of the following currently a concern for this child? (Please circle)

	Not at all	A little	Somewhat	Considerably	Always
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Alcohol or Substance Abuse	1	2	3	4	5
Parent-Child Conflicts	1	2	3	4	5
Sibling Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
Hyperactivity	1	2	3	4	5
Anger	1	2	3	4	5
School Problems	1	2	3	4	5
Self-Harm	1	2	3	4	5
Suicidal Ideation	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/Religious	1	2	3	4	5
Legal Problems	1	2	3	4	5
Feeding/Eating Concerns	1	2	3	4	5
Abuse **(**Physical, Emotional, Sexual)	1	2	3	4	5
High Caffeine Use	1	2	3	4	5
Hearing/Vision Challenges	1	2	3	4	5
Dental Problems	1	2	3	4	5
History of Trauma Experiences	1	2	3	4	5

Additional information regarding above areas:
Has this child received mental health services in the past: ☐ No ☐ Yes If 'Yes', where and when were services received:

Child's Name: _____Date: _____ **CHILD ADDITIONAL INFORMATION**

Do any members of the child's biological, adoptive, or extended family have a history of the following:

	YES	Relationship to Child
Anxiety (General)	☐	
Obsessive Compulsive Behavior	☐	
Depression	☐	
ADHD	☐	
Autism	☐	
Personality Disorder	☐	
PTSD	☐	
Suicide History	☐	
Bipolar/Manic Depressive	☐	
Alcoholism	☐	
Substance Abuse	☐	
Domestic Violence	☐	
Eating Disorders	☐	
Schizophrenia	☐	
Counseling or Psychotherapy	☐	
Psychiatric Hospitalizations	☐	
Other Family Mental Health History:	☐	

Cultural/ethnic/religious beliefs/practices of child/family and impact on mental health and mental health services:

Has this child experienced any major illnesses, medical services, or do they have any ongoing medical conditions:

☐ No ☐ Yes: _____

Has this child ever been hospitalized: ☐ No ☐ Yes: _____

Has this child ever had a head injury, loss of consciousness, or seizures: ☐ No ☐ Yes: _____

Current medications, dosages, and prescribing provider/s (include over-the counter items and supplements):

☐ No Current Medications

Any significant family health or medical history: ☐ No ☐ Yes:

Child's Name: _____Date: _____ **CHILD ADDITIONAL INFORMATION**

Current Living Environment

☐ Comfortable ☐ Supportive ☐ Chaotic ☐ Abusive
☐ Positive family relationships ☐ Family relational problems
☐ Home in good repair ☐ Home needs repair
☐ Safe neighborhood ☐ Safety concerns in the neighborhood
☐ Financially stable ☐ Financially stressed
Comments:

Complications during the pregnancy: ☐ No ☐ Yes: _____

Maternal substance/alcohol use prior to knowledge of being pregnant or during the pregnancy: ☐ No ☐ Yes

Maternal tobacco use during the pregnancy: ☐ No ☐ Yes

Length of Pregnancy: ☐ Full Term ☐ Premature Birth: _____

Complications during delivery: ☐ No ☐ Yes: _____

Birth Weight: _____ Length: _____

Mastery of Developmental Milestones	**Early**	**Average**	**Delayed**
Sitting without support	☐	☐	☐
Rolling over	☐	☐	☐
Crawling	☐	☐	☐
Walking alone	☐	☐	☐
First words	☐	☐	☐
2–3-word sentences	☐	☐	☐
Toilet trained – Daytime	☐	☐	☐
Toilet trained – Nighttime	☐	☐	☐

School History:

Attendance:	☐ Rarely Absent	☐ Sometimes Absent	☐ Frequently Absent
Academic Abilities:	☐ Above Average	☐ Average	☐ Below Average
Peer Relations:	☐ Above Average	☐ Average	☐ Below Average
Behavior:	☐ Above Average	☐ Average	☐ Below Average

Has this child been tested for special education: ☐ No ☐ Yes
Does this child have a current IEP/IFSP/504 Plan: ☐ No ☐ Yes

Additional information that you would like for the therapist to know about or to discuss during intake appointment:

Form Completed By: _____

Acceptance of Financial Responsibility

Client Name:_____ DOB:_____

By signing below as a client of Lake Country Associates, I agree to the following statements with regard to payment for services:

1. Clients are required to pay for services received. A client may choose to bill a third-party insurance including Medical Assistance and Medicare. In the event that the third-party insurance is billed, clients will be required to pay for all services which are not covered by insurance. Exceptions will include those items which are not appropriate to bill the client under the terms of the provider contract.
2. If clients choose to use insurance, they agree to provide insurance information to Lake Country Associates and agree to assist in billing for insurance reimbursement.
3. Self-pay clients are expected to pay for services at the time they are received. A 10% discount is offered for full cash payment at the time of service. LCA offers a Sliding Fee for those who qualify, please ask LCA Representative for more information.
4. Any services provided by LCA not covered by client's insurance which are 60 days in arrears may be charged monthly interest at a rate of 1.5% of the balance.
5. In the event of non-payment, the bill may be sent to collections.
6. LCA reserves the right to decline service or to require cash payment if a previous billing arrangement has not been honored.
7. The client agrees that if circumstances such as income, number of dependents, insurance or eligibility for various programs change, the client will notify LCA immediately.
8. No show or late cancellation (less than 24 hours) may result in a late cancellation/no show fee for the missed session.

Charges for services are to be billed to the following sources:

☐ Insurance (primary) Company_____Subscriber Name/Relationship _____
Group #_____Subscriber DOB _____
Policy # _____Subscriber Phone #_____
Co-Pay Amount _____Subscriber Address _____

☐ Insurance (secondary) Company_____Subscriber Name/ Relationship_____
Group #_____Subscriber DOB _____
Policy # _____Subscriber Phone #_____
Co-Pay Amount _____Subscriber Address _____

☐ Medical Assistance Carrier_____ MA#_____

☐ EAP Provider Name_____ Number of sessions_____

By signing below, I understand that if coverage has lapsed, or if services requested are not covered by the plan, or if plan caps have been exceeded, or if the services are denied by the carrier but, I wish to have them anyway, **that I will be responsible for the payment.** I also agree to any self-pay amounts indicated by the carrier contract. I authorize LCA to furnish information to the payment sources concerning my illness and treatments and hereby assign to Lake Country Associates all payments for services rendered to my dependents or myself. This authorization shall remain in effect until otherwise cancelled by Policy Holder or Representative. I understand my insurance carrier or other third-party payer may inform the "subscriber" of any services billed to the payer.

****

☐ **Private Pay Clients:**

Name_____Relationship_____

Address _____Phone # _____

By signing below, I agree that payment for services requested is the responsibility of the patient or guardian. I agree to accept the terms and conditions as indicated on the FEE SCHEDULE and PAYMENT CONTRACT. Any financial assistance that applies to these services is listed in the payment contract.

****

Client or Guardian Signature **Date** **LCA Representative**

Informed Consent for Assessment and Treatment

Name: _____ Date of Birth: _____

1. I understand that as a participant in mental health services at Lake Country Associates (LCA) I am eligible to receive a range of mental health services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.

2. I understand that all information shared with the clinicians at LCA is confidential and no information will be released without my consent. During the course of treatment at LCA, it may be necessary for my clinician, ARMHS Mental Health Practitioner or mental health provider to communicate with other LCA staff and clinical business associates of LCA. My authorization for the release of information with in LCA acknowledges my awareness of this communication. The purpose of this communication is to provide for continuity of care, consult on diagnosis, treatment planning or recommendations and is always done with the goal of providing the best and most appropriate services for my needs. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

    a. When there is risk of imminent danger to me or to another person; the clinician is ethically bound to take necessary steps to prevent such danger.
    b. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child or elder and to inform the proper authorities.
    c. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

3. I understand that a range of mental health professionals and practitioners, some of whom may be in training, provide LCA services. All professionals-in -training are supervised by licensed staff. I will be informed if the professional I am seeing is receiving supervision and is in training.

4. I understand that while psychotherapy may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories.

5. The Counselor-Client relationship is unique in that it is exclusively therapeutic. In other words, it is almost always inappropriate for a client and a counselor to spend time together socially, to give each other gifts, or to attend functions together. The purpose of these boundaries is to ensure that you and your counselor are clear in understanding your roles for treatment and that your confidentiality is maintained.

6. If there is ever a time when I believe that I have been treated unfairly or disrespectfully, I can discuss the situation with my mental health provider. Any issues that might interfere with the counseling process

should be identified and discussed as quickly as possible. This includes personal, family, administrative, financial and other issues.

7. Office Policies: Most counseling sessions last 45 - 50 minutes, but occasionally 20 - 30-minute sessions may be scheduled. We attempt to end each session promptly. Payment of co-pays or uncovered services is requested at the time of your appointment. We can accept cash, checks or credit cards for your payment. If you must cancel an appointment, we ask that you call our office at least 24 hours in advance. A late cancel or no showed appointment may result in a no-show fee. Repeated No Shows or Late Cancels may also result in limited availability for you to reschedule future appointments.

8. Our telephone is answered 24 hours a day by a digital answering system. Throughout the day we check messages and whenever possible we try to return phone calls the same day. If we have not returned your call within 24 hours, please try again. If you leave a message after office hours the message will be checked the following morning. On Fridays after closing at 1:00pm, calls go to the answering machine and will be checked on Monday mornings. If you have an emergency after hours or on the weekend, please call 911 or go to your closest emergency room.

9. LCA and its affiliates have my permission to contact me using the following methods:

Phone YES _____ (initial) _____ (Phone Number(s)) NO _____ (initial)

Text YES _____ (initial) _____ (Cell Phone Number) NO _____ (initial)

Email YES _____ (initial) _____ (Email Address) NO _____ (initial)

If I have any questions regarding this consent form or about the services offered at Lake Country Associates, I may discuss them with my mental health provider. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by Lake Country Associates. It is understood that either of us may discontinue the evaluation and treatment at any time and that I am free to accept or reject the treatment provided.

_____ _____

Client or Legal Guardian Signature **Date**

IF CLIENT IS A MINOR

In the case of a minor child, I hereby affirm that I am a custodial parent or legal guardian of the child and that I authorize services for the child under the terms of this agreement.

_____ _____

Signature of client's guardian **Date**

Name of minor child: _____

Minor child's date of birth: _____

Relationship to minor child: _____

Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Client Name: _____ Date of Birth: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Lake Country Associates' Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Ellie Anderson, MSW, LICSW at 218-366-9229 (Park Rapids) or Jessica Neimi, MSSW, LICSW at 218-444-2233 (Bemidji).

_____ _____
Client Signature Date

_____ _____
Parent, Guardian or Personal Representative Signature* Date

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

☐ Patient/Client refuses to acknowledge receipt:

_____ _____
Signature of LCA staff Date

Lake Country Associates, Inc.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors, clinical business associates, or other treatment team members. We may disclose PHI to any other consultant only with your authorization. We may also contact you to remind you of your appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

- **Child Abuse or Neglect.** We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

- **Judicial and Administrative Proceedings.** We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

- **Deceased Patients.** We may disclose PHI regarding deceased patients as mandated by state law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.

- **Medical Emergencies.** We may use or disclose your protected health information in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

- **Family Involvement in Care.** We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

- **Health Oversight.** If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

- **Law Enforcement.** We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

- **Specialized Government Functions.** We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

- **Public Health.** If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

- **Public Safety.** We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

- **Research.** PHI may only be disclosed after a special approval process.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Lake Country Associates, Inc., P.O. Box 806, 515 Bridge Street East, Park Rapids, MN 56470 Telephone: 218-366-9229.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Breach Notification.** If there is a breach of unsecured protected health information concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at 218-366-9229, or with the MN Department of Human Services, Attn: Privacy Official, PO Box 64998, St. Paul, MN 55164-0998, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

Additional Client Rights

Quality treatment:
You have the right to be treated in a professional, respectful manner. You have the right to expect quality and effective treatment.

Equal Access:
Lake Country Associates, Inc, provides equal access to employment, programs, and services without regard to race, color, creed, religion, age, gender, disability, marital status, sexual orientation, HIV status, public assistance, criminal record or national origin.

Minor Rights:
If you are a minor, you have a legal right to request that information about you not be shared with your parents. You will need to make this request in writing, state your reasons for withholding this information, and show that you understand the consequences of doing so. In a few cases we can withhold this information without your formal request. Feel free to discuss this with your therapist.

Treatment Planning and Goals:
You have the right and responsibility to participate in helping determine your treatment plan and reaching your goals. If you feel you have not been allowed to help in this process, or that a change in counselors might be helpful to you, please advise your counselor or contact the Clinic Director.

Supplying Information:
You have the right to refuse to supply the information we request. However, without certain information, we may not be able to provide you the services you request. If you feel certain information that we request is an unwarranted invasion of privacy, please ask us for clarification.

Staff Rights*:*
Staff have the right:

- *To preserve their personal life and to receive respect for their personal privacy;*
- *To courtesy and freedom from verbal abuse, harassment and threats;*
- *To your full cooperation and participation in the therapy process;*
- *To your reliability and promptness in keeping appointments;*
- *To 24 hour notice when you must cancel an appointment;*
- *To terminate treatment or recommend a transfer if reasonable progress is not being made.*

The effective date of this Notice is April 1, 2010.
Revised August 16, 2012.

In-Person Services - COVID

This document contains important information about Lake Country Associates, Inc's decision to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let your provider or administrative assistant know if you have any questions. When you sign this document, it will be an official agreement between Lake Country Associates, Inc and the client.

Decision to Meet Face-to-Face
We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, it may be required that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, your will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services are determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone (clients, providers, administrative staff, and families) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in resuming telehealth services for everyone's well-being.

You understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free.
- Your temperature will be taken using an infrared thermometer before each appointment. If it is elevated (100.4 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth.
- You will wait in your car, outside, or if the weather makes it difficult to stay outside – in the lobby. Please do not arrive more than 5 minutes before your appointment. You will be notified by your provider when it's a safe time for you to enter the building.
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building.
- You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room.
- It is recommended that you wear a mask in all areas of the office and in interactions with our providers and administrative staff.
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with providers or administrative staff.
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols.
- You will take steps between appointments to minimize your exposure to COVID.
- If you are exposed to other people who are infected or test positive for COVID, you will immediately let your provider or administrative staff know.

The above precautions may change if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure
Lake Country Associates, Inc has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please contact your provider or administrative staff if you have questions about these efforts.

If You or Your Provider Are Sick
You understand that Lake Country Associates, Inc is committed to keeping our clients, staff, and all of our families safe from the spread of this virus. If you show up for an appointment and Lake Country Associates, Inc staff believe that you have a fever or other symptoms, or believe you have been exposed, we will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If a Lake Country Associates, Inc staff member tests positive for the coronavirus, you will be notified so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, Lake Country Associates, Inc may be required to notify local health authorities that you have been in the office. If Lake Country Associates, Inc has to report this, the minimum information necessary for their data collection will be given. No details about the reason(s) for our visits will be shared. By signing this form, you are agreeing that Lake Country Associates, Inc may do so without an additional signed release.

Informed Consent
This agreement supplements the general informed consent that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____
Client Printed Name

_____ _____
Client or Legal Guardian Signature Relationship to Client

_____ _____
Provider Signature Date

Telehealth Informed Consent

Telehealth is healthcare provide by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

- I consent to engaging in telehealth with Lake Country Associates, Inc. as part of the therapy process. I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format. I understand that the telehealth sessions are not recorded but rather are set in real time between myself and the clinician.
- I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at Lake Country Associates, Inc.
- I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.
- I understand that all electronic medical communications carry some level or risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include, but are not limited to:
    - It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
    - Electronic systems that are accessed by employers, friends, or others are NOT secure and should be avoided. It is important for me to use a secure network.
    - Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.
- I understand that Skype, Face Time, or a similar service may not provide a secure HIPPAA-compliant platform, but I willingly and knowingly wish to proceed. Lake Country Associates typically encourages and recommends the use of VIDYO for telehealth as it is a secure and encrypted telecommunication program.
- The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.
- I agree that information exchanged during my telehealth visit will be maintained by healthcare providers and the agency involved in my care.
- I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications. Moreover, there are both mandatory and permissive exceptions to confidentiality including but not limited to, reporting child and vulnerable adult abuse, expressed imminent harm to myself or others, or as part of legal proceedings where information is requested by a court of law.
- I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

- I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).
- I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.
- I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.
- I understand that I have a responsibility to verify the identify and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.
- I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As a client, I agree to accept responsibility for following my healthcare providers recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.
- I understand that there is never a warranty or guarantee as to a particular result of outcome related to a condition or diagnosis when medical care is provided. Furthermore, I understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and the efforts of my therapist, my condition may not improve, or may have the potential to get worse.
- To the extent permitted by law, I agree to waive and release my healthcare provider and his/her institution or practice from any claims I may have about the telehealth visit.
- I understand the inherent risks of errors or deficiencies in the electronic transmission or health information and images during a telehealth visit.
- **I understand that electronic communication cannot be used for emergencies or time sensitive matters. If I am in crisis or in an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. I understand that emergency situations include but are not limited to: thoughts about hurting/harming myself or others, having uncontrolled psychotic symptoms, if I am in a life-threatening situation, and/or if I am abusing drugs or alcohol and am not safe.**

I certify that I have read and understand this agreement and that I have had the opportunity for questions to be answered to my satisfaction.

For electronic communication between Lake Country Associates, Inc. and _____
Client's Printed Name

_____ _____
Client or Legal Guardian Signature Relationship to Client

_____ _____
Email Address Date

*Are you Interested in **STRICTLY TELEHEALTH VISITS:** ☐ Yes ☐ No*