Informed Consent

Laura McAuliffe, MSC, MFT
Wayne McAuliffe, MS, MSC, MFT

9492 Double R Blvd, Suite B
Reno, NV 89521

Therapists:

1. We are licensed Marriage and Family Therapists in the State of Nevada. We have Master of Counseling degrees in Marriage, Family, and Child Therapy.
2. All Marriage and Family Therapists are required by law and professional ethics to keep your information confidential except under the limitations noted below, including in consultation with colleagues. Consultation with other providers, past or present, regarding specifics of your treatment will require a signed authorization for release of information.
3. The therapists have been trained in a variety of specific methods of treatment and will determine what approaches and techniques might be most effective with your particular needs.
4. We do not diagnose or treat psychotic disorders, and we do not give assessment tests to determine intelligence, personality, aptitude, or interests.
5. As providers of therapeutic services we do not conduct forensic evaluations or render opinions regarding child visitation or child custody.

_____Initial here that this section has been read and understood

Confidentiality and limitations

1. The confidentiality of the counseling provided by us is protected by law. Unless you grant us written permission to do so, therapists will neither inform anyone that you are receiving therapy, nor will therapists disclose content of any session.
    a. The following are the legal exceptions to your right to confidentiality in accordance with NRS 432B.220 and NRS 200.5091-5095:
    b. any accounts of child abuse/neglect, past or present,
    c. Any situations in which someone is threatening themselves or others with physical harm- If either of us has a valid reason to believe that you are in imminent danger of harming yourself, we are required to break confidentiality and contact the police. However, whenever possible, we would explore all other options with you before taking this step.
    d. any account of abuse, neglect, or exploitation of senior citizens, past or present
    e. when client information is court ordered to be released

    For any of these exceptions, we would only reveal the information necessary to protect you or the person in danger, or to meet legal requirements. We would not divulge everything you told us.

_____Initial here to indicate this section has been read and understood.

Billing Policies:

1. The fee for services or your co-pay is due at the conclusion of each session. Any overpayments will be returned to you once we have received full payment for services by the insurance provider.
2. The client is always responsible for the payment of costs incurred for services rendered, regardless of benefits. This means that if for whatever reason a claim from this office is denied, you are responsible for the remaining balance of the bill.
3. Your appointment time has been set aside specifically for you. You are responsible for coming to your session on time. If you are late for your session, we will still end on time and your full regular session fee will apply.
4. We charge $50 per 15 minutes or portion thereof of therapy over the phone. Incidental costs, such as those incurred via international calls, will also be billed at our cost.
5. If you are unable to attend your appointment, you MUST cancel at least 24 hours in advance. If you do not cancel more than 24-hours in advance or miss a session without canceling, you may be responsible to pay the full regular session fee.
6. If you request that I write reports for schools, employers, attorneys, doctors, courts, Child Protective Services, etc., you will be charged for the time it takes to write the report at a rate of $50 per 15-minute interval.

7. Court Appearances: Our rate for court appearances is $350 per hour or portion thereof, including transportation time, plus any applicable travel/lodging costs, to be paid from client's attorney's retainer. Please note: as providers of therapeutic services we do not render opinions regarding child visitation or child custody.
8. If a check is returned for insufficient funds, a $25.00 fee will be assessed in addition to the session fee.
9. We do not encourage the giving of gifts, and we may not accept any gift of substantial value.

_____Initial here to indicate this section has been read and understood.

Diagnostic purpose

1. If you elect to use your insurance plan to assist in the payment for treatment, then the insurance carrier and the National Information Center will have access to your diagnosis code and other pertinent data needed for claim processing.

_____Initial here to indicate this section has been read and understood.

Statement of Understanding

Each of the undersigned has read the policies and procedures, asked any questions necessary, and understand the terms of this consent. I understand my rights and responsibilities as a client and my therapist's responsibilities to me. I agree to these conditions and consent to treatment.

_____	_____	_____	_____
Client Signature (or Parent/Legal Gaurdian)	Date	Client Signature (or Parent/Legal Gaurdian)	Date
_____	_____	_____	_____
Client Signature	Date	Client Signature	Date

_____ _____

Therapist's Signature Date

HIPAA

I have received the HIPAA notification from Laura McAuliffe, MS or Wayne McAuliffe, MS:

Printed name: _____ Date:_____

Signature: _____

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Telehealth addendum:

1. Telehealth is the delivery of health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client/patient who are not in the same physical location.
2. The interactive technologies used in telehealth incorporate network and software security protocols to protect the confidentiality of client/patient information transmitted via any electronic channel. In spite of measures taken to encrypt and protect communications, risks include but are not limited to breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.
3. Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.
4. I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided.
5. The exchange of information will be indirect and any signed documentation exchanged will be provided through electronic means or through postal delivery.
6. During my telehealth session, details of my medical history and personal health information will be discussed through the use of interactive video, audio or other telecommunications technology.
7. If a need for direct, in-person services arises, it is my responsibility to contact practitioners in my area for an in-person appointment, potentially including my primary care physician or emergency services if my behavioral practitioner is unavailable.
8. I may decline any telehealth services at any time without jeopardizing my access to future care, services, and benefits.
9. In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means.
10. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted or required by law may also have access to records or communications.
11. The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.
12. Payment (e.g. for co-pays) via credit/debit/HSA card will be done via secure Square invoicing. Please provide an e-mail address for invoicing:

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e-mail address for invoicing

Each of the undersigned has read the policies regarding telehealth, asked any questions necessary, and understand the terms of this consent. I agree to these conditions and consent to treatment via telehealth.

_____	_____	_____	_____
Client Signature (or Parent/Legal Gaurdian)	Date	Client Signature (or Parent/Legal Gaurdian)	Date
_____	_____	_____	_____
Client Signature	Date	Client Signature	Date
_____	_____		
Therapist's Signature	Date		

3/16/2020