Liberated Counseling, LLC

Information Sheet

Client Information:

Legal Name: _____ DOB: _____

Preferred Name: _____ Social Security Number: _____

Gender Identity: _____ Gender Marker on ID: _____

Pronouns: _____ Ethnic Identity: _____

Sexuality: _____ Religious Identity: _____

Other Identity: _____ Other Identity: _____

Primary Language: _____ Proficiency of reading / writing in this language: _____

Email, text messaging, and other electronic communications are not secure mediums and therefore, confidentiality cannot be assured. Please use discretion when sending information that is sensitive in nature.

Cell Phone _____ May I leave a message? YES NO

Marital Status: _____ May I text you? YES NO

Email: _____ May I email you? YES NO

Home Address: _____

Significant Relationship(s): _____

Relationship Agreement(s): _____

Emergency Contact(s):

_____ Ok to Contact? YES NO

(Name) (Relationship) (Telephone Num.)

_____ Ok to Contact? YES NO

(Name) (Relationship) (Telephone Num.)

Parent(s) / Guardian(s) Information:

Name: _____

Cell Phone: _____ May I leave a message? YES NO

May I text you? YES NO

Email: _____ May I email you? YES NO

Name: _____

Cell Phone: _____ May I leave a message? YES NO

May I text you? YES NO

Email: _____ May I email you? YES NO

Insurance / Payment Information:

Payment Source: Self Pay Sliding Scale Medical Insurance

Insurance Company: _____ Client's Relationship to the Policy Holder:

Policy Holder's Name: _____ Self Partner Dependent

Policy Holder's DOB: _____ Member #: _____

Policy Holder's SSN: _____ Group #:

Policy Holder's Employer: _____

Liberated Counseling, LLC

Intake Questionnaire

Please complete the following questionnaire before your first appointment. This helps me complete an intake assessment and get an overall picture of your current struggles and strengths. While some of these questions may seem like asking a lot of information, most of these questions are required by the norms of the counseling field to provide you the best possible service. Thanks!

Reason for seeking counseling: _____

_____

_____

Presenting Concerns (please check all that apply)

- ☐ Suicidal Thoughts
- ☐ Problems with Child / Children: _____
- ☐ Defiance / Oppositionality
- ☐ Anxiety / Worries
- ☐ Confusion
- ☐ Depression
- ☐ Difficulty Being Alone
- ☐ Fatigue
- ☐ Guilt / Shame
- ☐ Hearing Voices / Hallucinations
- ☐ Memory / Concentration Problems
- ☐ Mood Swings
- ☐ Motivation Reduced / Absent
- ☐ Obsessive Thoughts
- ☐ Panic (or Anxiety) Attacks
- ☐ Physical Abuse
- ☐ Low Self-Esteem
- ☐ Weight Change
  - ☐ Increase ☐ Decrease
- ☐ Sexual Abuse
- ☐ Sleep Problems
- ☐ Trauma / PTSD
- ☐ Struggles Attaching / Having Relationships
- ☐ Grief and Loss
- ☐ Coming out / GLBTQ Concerns
- ☐ Unusual Thoughts
- ☐ Body Image Concerns
- ☐ Anger / Aggression / Violence
- ☐ Parent / Child Conflict
- ☐ Social Struggles
- ☐ Drug / Alcohol Use Concerns
- ☐ Addiction
- ☐ Eating Habits / Problems
- ☐ Lying Frequently
- ☐ Perfectionism
- ☐ Physically Abusive to Self
- ☐ Other: _____
- ☐ Other: _____
- ☐ Shy, Uneasy with Others
- ☐ Passive / Unassertive
- ☐ Unwanted Behavior / Habits
- ☐ Withdrawn
- ☐ Employment / School Issues
- ☐ Legal Problems
- ☐ Living Arrangements
- ☐ Money Management Issues
- ☐ Parenting Issues
- ☐ Relationship / Marital Issues
- ☐ Cutting / Self-Harm
- ☐ Existential / Spiritual Struggles
- ☐ Divorce / Separation
- ☐ Communication Struggles
- ☐ Individual Sexuality Concerns
- ☐ Personal Pleasure Concerns
- ☐ Couple Sexuality Concerns
- ☐ Relationship Pleasure Concern

Prior Behavioral Health Experiences

1. Outpatient Counseling (most recent, to first)

Dates: From – To	Clinic	Therapist	Reason / Results (How was it?)

2. Intensive Treatment (including residential treatment, treatment foster care, and hospitalizations)

Dates: From – To	Clinic	Therapist	Reason / Results (How was it?)

Medical History (current and in the past)

Medical Conditions in the last year: _____

Chronic Illnesses: _____

Surgeries: _____

Head Injuries (TBI diagnosed or otherwise): _____

Disabilities (physical or developmental): _____

Allergies: _____

Advanced Directives (if applicable): _____

Medication	Dose/Frequency	Start Date	End Date	Reason for RX	Prescribed By

Drug and Alcohol Use History:

Past Use	Type	Quantity	Frequency	Date Started (If applicable)	Date Ended (If applicable)
Alcohol					
Tobacco					
Non-Prescribed Drugs					

Describe your daily caffeine consumption (tea, coffee, soda, etc.): _____

Are you satisfied with your eating patterns?	☐ YES	☐ NO
Does your weight affect the way you feel about yourself?	☐ YES	☐ NO
Do you make yourself **S**ick because you feel uncomfortably full?	☐ YES	☐ NO
Do you worry you have lost **C**ontrol over how much you eat?	☐ YES	☐ NO
Have you recently lost more than 14 lb in 3-month time?	☐ YES	☐ NO
Do you believe yourself to be **F**at when others say you aren't?	☐ YES	☐ NO
Would you say that **F**ood dominates your life?	☐ YES	☐ NO

Education and Employment (if applicable):

1. Education History

Highest level of education to date: _____

Current School / Field of Study: _____

2. Employment History

Are you currently employed? YES NO Job Title: _____

Do you have any concerns about employment? YES NO : _____

3. Military Experience

Have you been in any branch of the military? YES NO Branch _____ Position _____

Reason for Discharge: _____

Liberated Counseling, LLC

CONSENT TO TREATMENT

It is the policy of Liberated Counseling LLC that clients have the right to say whether they wish to receive Outpatient services. Each client has impartial access to treatment, regardless of race, religion, gender identity, ethnicity, age, sexual preference or disability, within the range and diagnostic criteria for which Liberated Counseling LLC provides treatment.

The undersigned acknowledges that Liberated Counseling LLC makes no guarantees to the undersigned or the client as to the results or likelihood of success of Liberated Counseling LLC services.

The undersigned acknowledges that if a client becomes dangerous to him/herself or to others, the staff will exercise the necessary precautions to protect the client or others.

The undersigned acknowledges receiving a copy of information about Liberated Counseling including policies and procedures, Informed Consent, HIPPA compliance protocols, and Notice of Privacy Practices.

The undersigned releases Liberated Counseling LLC staff from any liability for the loss or damage of personal property and/or money while receiving services at Liberated Counseling LLC or at the client's home.

These services are completely voluntary:

☐ **Yes; I Consent** to receive outpatient services from Liberated Counseling LLC for myself or on the behalf of the client.

☐ **No; I Do Not Consent** to receive outpatient services from Liberated Counseling LLC for myself or on the behalf of the client. Referrals for outside services or alternative services can be supplied upon request.

My signature below attests to the fact that I have read this form, understand its content and request that the above information be released as specified.

_____ _____

CLIENT SIGNATURE (REQUIRED FOR AGE 14+) DATE

_____ _____

PARENT / GUARDIAN SIGNATURE DATE

I have discussed the notice of privacy practices, informed consent, consent to treatment, consent to policies and disclosure to insurance company, consent to payment policies, consent to cancellation policy, and client rights and responsibilities with the client(s) and/or their parent/guardian (if applicable). My observations of their behavior and responses give me reason to believe that this person is fully competent to give informed and willing consent. My signature below attests to this statement.

_____ _____

STEPHEN RATCLIFF, MA, LPCC (NM), LPC (OR), NCC, CST DATE

Cell (505) 504-5449 www.liberatedcounseling.com steve@liberatedcounseling.com

Liberated Counseling, LLC

CONSENT TO POLICIES AND CONSENT TO DISCLOSURE TO INSURANCE COMPANY

Thank you for choosing Liberated Counseling as your therapy provider. Please carefully review the consent to disclosure to insurance companies (if applicable) and receipt of notice of privacy practices below. If you agree to each item, please initial next to each statement indicating your agreement and sign at the bottom.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____I acknowledge that I have been provided a Notice of Privacy Practices that fully explains the uses and disclosures that Liberated Counseling will make with respect to my individually identifiable health information. I understand that I have the right to review said notice before signing this consent. Additional copies of this notice are posted on the website www.liberatedcounseling.com and in the office. I also understand that Liberated Counseling reserves the right to change its notice and the practices detailed therein prospectively and will notify me of any changes.

RECEIPT AND CONSENT TO INFORMED CONSENT AND ADDITIONAL POLICIES

_____I acknowledge that I have been provided and reviewed a copy of Informed Consent, additional privacy policies and cancellation and no-show policy. I understand these policies and agree to abide by the boundaries and stipulations therein.

_____I understand the limits of confidentiality in communication by electronic means. I will use discretion when electronically communicating information to this therapist.

CONSENT TO DISCLOSURE TO INSURANCE COMPANY (IF APPLICABLE; OPTIONAL)

_____I understand that I do not have to consent to the uses or disclosure of my individually identifiable health information for treatment, payment, and health-care operation. I also understand that if I do not consent, Liberated Counseling may refuse to provide me health-care services unless applicable state or federal law requires Liberated Counseling to provide such services.

_____I understand that I may revoke this consent in writing, but that the revocation will not be effective to the extent that Liberated Counseling has already acted in reliance on my earlier effective consent.

_____I understand that as part of my healthcare, Liberated Counseling originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among health professionals who contribute to my care.
- A source of information for applying my diagnosis information to my bill.
- A means by which a third-party payer can verify that services billed were provided.

_____I understand that if my medical insurance company is providing payment for services rendered at Liberated Counseling, the following disclosures of my identifiable health information may apply:

- Liberated Counseling will have to release information including dates of sessions, CPT codes billed, and diagnostic information about me to my insurance company, or their legal representative to obtain payment.
- If records are requested by my insurance company as a requirement to process payment for services rendered, Liberated Counseling will attempt to notify me of the documents being disclosed and permit me to review them prior to their disclosure. Documents may include any documents generated by Liberated Counseling about me.
- I will have to authorize my insurance company to make benefits payable to Liberated Counseling.

My signature below attests to the fact that I have read this form, understand its content, and agree to these conditions.

_____ _____

CLIENT SIGNATURE (REQUIRED FOR AGE 14+) DATE

_____ _____

PARENT / GUARDIAN SIGNATURE DATE

_____ _____

STEPHEN RATCLIFF, MA, LPCC (NM), LPC (OR), NCC, CST DATE

Cell (505) 504-5449 www.liberatedcounseling.com steve@liberatedcounseling.com

Liberated Counseling, LLC

Please carefully review the financial policies outlined below. Please initial next to each statement indicating your agreement. *Please note that unless insurance utilization or a reduction in fee is set-up in advance, the **Good Faith Estimate for services** is the same as the full-scale fees outlined below*.

CONSENT TO PAYMENT POLICIES

PAYMENT POLICIES

_____ I understand that all Copays, Deductible payments, Self-pay, or Sliding-scale fees are due at the time or service. If my insurance company denies paying for my services or indicates a deductible payment or different copay amount than indicates on my insurance card, then these payments are due five business days after I am invoiced.

_____I understand that if I don't have insurance, I will be expected to pay the noted fee (or sliding scale fee) for these services at each appointment. Any payments may be made via cash, check, or credit card.

_____I understand that the full-scale fees for services are as follows: Intake Appointments **$250**, After Hours Therapy **$200** per 55 minutes, Individual Therapy Appointments **$200** per 55 minutes, Relationship Therapy Appointments **$175** per 55 minutes, and **$45** fee for the Gottman Relationship Checkup Assessments for couples' clients.

_____I understand that any balances not paid within 30 calendar days may be turned over to collections with an additional 2% late fee added. I understand that if my bill must be turned over to collections due to not paying my balance after 30 calendar days, I am responsible for the collection's fees (typically 40% of the total bill).

_____I understand that if payment for the services I receive is not made, the therapist may stop my treatment.

_____I understand that if I pay by check or with credit card and the payment is later recouped (e.g. the check bounces), a fee of **$50 per incident** will be incurred. I understand that this balance must be paid by alternative means in 5 days.

ADDITIONAL SERVICES

_____ I understand that any out of session communication (telephone call or other medium) lasting more than 5 minutes will result in a fee of **$25** per 15 minutes. There will be no fee for contacts lasting less than 5 minutes.

_____ I understand that other miscellaneous services (e.g. record preparation) cost **$25** per 15 minutes.

_____ I understand that if I choose to subpoena Stephen Ratcliff, all legal services including preparation time, testimony time, transportation time, and commute time will incur a fee of **$500** per hour due prior to testimony date.

CONSENT TO CANCELLATION POLICY

_____I understand that if I am unable to attend my scheduled therapy appointment, I must first notify Liberated Counseling by email or at 505-504-5449 by text or voicemail 24 hours in advance of my appointment.

_____ I understand that If I do not call to cancel or reschedule my appointment, this will be considered a **no-show**. Additionally, arriving later than 20 minutes for my scheduled therapy appointment time constitutes a no-show. No-shows to appointments are not covered by my health insurance and will result in a subsequent fee of **$25**.

_____ I understand that reoccurring no-shows / same day cancellations (2 instances in 12 months) may result in the termination of services. I understand that if I miss my scheduled appointment, it is my responsibility to call to set up another appointment. I understand that if I don't respond to contact attempts from Liberated Counseling, this will be interpreted as communication that I no longer wish to receive services.

_____ I understand that if extenuating circumstances arise and I cancel in advance of my appointment but not with 24 hours' notice, Liberated Counseling may choose to waive this fee on a case-by-case basis.

_____ I understand that if I miss my scheduled appointment, it is my responsibility to call to set up subsequent appointments. Failure to cancel with 24-hour prior notice *may* result in me losing my preferred time slot. If I am failing to maintain contact, Liberated Counseling may take this as communication that I am terminating services.

My signature below attests to the fact that I have read this form, understand its content, and agree to these conditions.

_____ _____

CLIENT SIGNATURE (REQUIRED FOR AGE 14+) DATE

_____ _____

PARENT / GUARDIAN SIGNATURE DATE

_____ _____

STEPHEN RATCLIFF, MA, LPCC (NM), LPC (OR), NCC, CST DATE

Cell (505) 504-5449 www.liberatedcounseling.com steve@liberatedcounseling.com

Liberated Counseling, LLC

CLIENTS RIGHTS AND RESPONSIBILITIES

Client's Rights

1. The right to efficient and equal service, regardless of race, gender, religion, ethnic background, education, social class, physical or mental disability, sexual orientation, gender identity, or economic status.
2. The right of considerate, courteous, and respectful care from all Liberated Counseling, LLC staff.
3. The right to informed consent and full discussion of risks and benefits prior to any invasive procedure, except in an emergency. Alternative to the proposed procedure must be discussed with the client.
4. The right to receive information in an understandable manner.
5. The right to obtain a referral for bi-lingual services or to have an interpreter present in session if needed.
6. The right to the names, titles, and professions of Liberated Counseling, LLC staff with whom the client speaks and from whom services or information are received.
7. The right to refuse examination, discussion, and/or procedures to the extent permitted by law and to be informed of the health and legal consequences of this refusal.
8. The right of access to the client's own personal health record.
9. The right to confidentiality and privacy of the client's personal mental health records as provided by the law. The details of the client's life and treatment are shared only with the client's parent's or guardian's permission and the client's explicit consent.
10. The right to expect reasonable continuity of care within the scope of services of Liberated Counseling, LLC.
11. The right to examine and receive a full explanation of any charges made by Liberated Counseling, LLC regardless of the source of payment.
12. The right of respect for the client's civil rights and religious opinions.
13. The right to be represented by a family member of guardian if the client is unable to fully participate in treatment decisions.

Client's Responsibilities

1. Provide accurate and complete information relevant to your treatment at Liberated Counseling, LLC.
2. Ask questions if you do not understand any aspect of your treatment.
3. Report safety concerns immediately to your therapist.
4. Avoid drugs, alcoholic beverages, or toxic substances while in attendance of your therapy session.
5. Accept the consequences if you do not follow the care, service, or treatment plan provided to you.
6. Respect the property of other people and of Liberated Counseling, LLC.
7. Be considerate of other clients.
8. Sign a written acknowledgement that you have received the applicable Notice of Privacy Practices.
9. Provide accurate information needed for processing your insurance coverage.
10. Be responsible for payment of all services, either through your third-party payers (insurance company) or by personally making payment for any service that are not covered by your insurance policy(s) including second opinions or consultations.

By signing below, I acknowledge my client's rights and responsibilities listed herein.

_____ _____

CLIENT SIGNATURE (REQUIRED FOR AGE 14+) DATE

_____ _____

PARENT / GUARDIAN SIGNATURE DATE

_____ _____

STEPHEN RATCLIFF, MA, LPCC (NM), LPC (OR), NCC, CST DATE

Cell (505) 504-5449 www.liberatedcounseling.com steve@liberatedcounseling.com

Liberated Counseling, LLC

PRIMARY CARE PHYSICIAN COORDINATION OF CARE RELEASE FORM

CLIENT NAME: _____ DATE OF BIRTH: _____

THIS WILL AUTHORIZE: Liberated Counseling, LLC

Tel. (505) 504-5449 Email steve@liberatedcounseling.com

TO RELEASE TO: _____

(Facility, organization, individual receiving information)

_____

(Telephone, fax, address)

Cancellation / Expiration: I understand that I may cancel this authorization at any time by sending my health providers my cancellation notice in writing. I understand that my health care providers may have already released records according to this authorization prior to receiving my notice of cancellation.

This authorization shall remain valid for one year from the date of signature unless revoked in writing by the client's guardian or conservator. This authorization releases Liberated Counseling, LLC from all legal liability that may arise as a result of compliance with this release of information request.

I authorize Liberated Counseling, LLC to have contact and release medical records to the Physician noted above.

I specifically authorize the release of my medical records to include the following records (initial):

_____ HIV / AIDS results and treatments
_____ Sexually transmitted or "communicable" disease Information
_____ Prescription Drug Information
_____ Drug, alcohol, or substance abuse Information
_____ Mental health Information (other than psychotherapy notes)

I do not authorize Liberated Counseling, LLC to release medical records.

My signature below attests to the fact that I have read this form, understand its content and request that the above information be released as specified.

_____ _____
CLIENT SIGNATURE (REQUIRED FOR AGE 14+) DATE

_____ _____
PARENT / GUARDIAN SIGNATURE DATE

I have discussed the above form and what information may or may not be disclosed with the client(s) and/or their parent/guardian (if applicable). My observations of their behavior and responses give me reason to believe that this person is fully competent to give informed and willing consent. My signature below attests to this statement.

_____ _____
STEPHEN RATCLIFF, MA, LPCC (NM), LPC (OR), NCC, CST DATE

Liberated Counseling, LLC

Cell (505) 504-5449 www.liberatedcounseling.com steve@liberatedcounseling.com

TELEHEALTH INFORMED CONSENT

This form will go over a little bit about telehealth, how to electronically complete intake and other paperwork, and will help you set up the tools for our video telehealth sessions.

- We will use secure, encrypted technologies that are free to you for video sessions.
- Telehealth has both benefits and risks, which we will be monitoring as you proceed with your work.
- You can stop work by telehealth at any time without prejudice.
- You will need to participate in creating an appropriate space for your telehealth sessions.
- You will need to participate planning for technology failures, mental health crises, and medical emergencies.
- I follow security best practices and legal standards in order to protect your health care information, but you will also need to participate in maintaining your own security and privacy.

What is Telehealth?

Telehealth means the providing of mental health counseling through secure video software. Services delivered via telehealth rely on a number of electronic, Internet-based, programs. I provide telehealth via a secure application called vsee messenger or a secure website called doxy:

- Vsee messenger can be downloaded for free here: https://my.vsee.com/download
- If you prefer, we can also meet through the secure doxy website. My doxy's website is https://doxy.mee/sratcliff
- You will need access to high speed Internet service for your telehealth session.
- If you have any questions or concerns about the above tools, please let me know.

POTENTIAL TELEHEALTH BENEFITS

- Receive services when you are unable to travel to the service provider's office.
- Receive services at times or in places where the service may not otherwise be available.
- Receive services in a fashion that may be more convenient and less prone to delays than in-person meetings.
- Receive services without potential risks of transmission of COVID 19 or other transmittable viruses.
- The unique characteristics of telehealth media may also help some people make improved progress on health goals that may not have been otherwise achievable without telehealth.

POTENTIAL TELEHEALTH RISKS

Telehealth services can be impacted by technical failures, may introduce risks to your privacy, and may reduce my ability to directly intervene in crises or emergencies. Here is a non-exhaustive list of examples:

- Internet connections and cloud services could cease working or become too unstable to use.
- Computer or smartphone hardware can have sudden failures or run out of power, or local power services can fail.
- Interruptions may disrupt services at important moments, and I may be unable to reach you quickly.

Assessing Telehealth's Fit for You

- Although it is well validated by research, service delivery via telehealth is not a good fit for every person. I will continuously assess if working via telehealth is appropriate for your case. If it is not appropriate, I will help you find in-person providers or shift to in-person sessions.
- Please talk to me if you find the telehealth media so difficult to use that it distracts from the services being provided, if the medium causes trouble focusing on your services, or if there are any other reasons why the telehealth medium seems to be causing problems in receiving services.
- Bringing your concerns to me is often a part of the process. You also have a right to stop receiving services by telehealth at any time without prejudice.

Your Telehealth Environment

You will be responsible for creating a safe and confidential space during sessions. Please consider:

- Dress as you would if we were meeting in an office appointment.
- If you have a headset with a microphone, please use it as this helps produce better audio and privacy.
- Please be in an environment where you are alone and have good access to high speed internet.
- Please limit distractions such as multi-tasking. Please turn on do not disturb if you are meeting on your cell phone.
- Have your computer or tablet on a firm surface if possible.
- Please avoid walking around with your device, as this can make me dizzy.

Communication Plan

If you need to get ahold of me in between sessions, here are some contact methods and considerations:

- The best way to contact me between sessions is by email steve@liberatedcounseling.com or telephone 505-504-5449. *Please note that neither email nor my telephone number are to be used during a crisis*.
- I will respond to your messages as soon as I can. Please note that I may not respond at all on weekends or holidays.
- Our work is done primarily during our appointed sessions, which will generally occur during my business hours Monday thru Thursday from 10am to 7pm.
- Contact between sessions should be limited to confirming or changing appointment times.

Technology Safety and Crisis / Emergency Planning

As a recipient of telehealth services, you will need to participate in ensuring your safety during mental health crises, medical emergencies, and sessions that you have with me.

- I will require you to designate an emergency contact at the intake appointment. You will need to provide permission for me to communicate with this person about your care during emergencies.
- Crisis services include Telephone crisis lines (800-273-8255), calling 911, or go to the nearest Emergency Room.
- Except where otherwise noted, I employ software and hardware tools that adhere to security best practices and applicable legal standards for the purposes of protecting your privacy and ensuring that records of your health care services are not lost or damaged.
- As with all things in telehealth, however, you also have a role to play in maintaining your security. Please use reasonable security protocols to protect the privacy of your own health care information. For example: when communicating with me, use devices and service accounts that are protected by unique passwords that only you know. Also, use the secure tools that I have supplied for communications (e.g. Vsee). For more information please see my specific recommendations for electronic security and safety here: http://steveratcliff.com/techrec.pdf

Instruction for Setting Up Vsee or getting onto the doxy website

- Vsee messenger can be downloaded for free here: https://my.vsee.com/download
    - After you download and install vsee messenger onto a tablet, computer, or smart phone, you will need to set up an account. This process if free but will include using an email address for that account.
    - If you have problems downloading vsee messenger, let me know and I can email you a download invite
    - After you have set up the application and account, let me know what email address you used, and I will reach out to you through the application to connect us.
    - After we are connected, we can send messages, do video sessions, and exchange files securely through the end-to-end encryption that vsee messenger uses.
    - A video showing some of the basic functions of the vsee messenger application is here: https://youtu.be/XZlCfj07MUQ
- If you prefer, we can also meet through the secure doxy website, which is https://doxy.me/sratcliff
    - Click on the link and check in a few minutes prior to our appointment time using whatever name.
    - It will ask you to enable access to your microphone and camera. Click yes.
    - I will start the appointment at our appointment time.
    - This webpage is a tutorial for doxy https://help.doxy.me/en/articles/3751218-how-to-check-in-as-a-patient
- Call me at 505-504-5449 if there are technical difficulties.

Recordings
Please do not record video or audio sessions without my consent. Making recordings can quickly and easily compromise your privacy and should be done so with great care. I will not record video or audio from our sessions.

Insurance Coverage and Payment Information

- Currently, telehealth services are only permitted to residences of New Mexico, Oregon, and Florida due to licensure law restrictions (I am only licensed or permitted to practice in these states).
- Many insurance companies cover some or all of the cost of services delivered by telehealth. If you have questions about coverage of telehealth, please contact your insurance company.
- Copays and deductibles will be due at the time of service during a telehealth session similar to an in-office session. These fees will be collected by cash, check, credit card, HSA, or FSA means.
- Any credit card, debit card, HAS, or FSA payments will be collected using a secure service called **Ivy**, which keeps your card on file. Your signature at the bottom of this form indicates your consent to Ivy maintaining your chosen card on file. Ivy can delete your card information upon request.

Electronically Signing Paperwork
Prior to our first appointment and periodically throughout therapy, we will need to complete paperwork. I have made my forms fillable online for your convenience. Here are some tips to help you fill out these forms:

- You may fill out forms securely in electronic form or download the forms: www.liberatedcounseling.com

Please indicate your consent choice for receiving services by telehealth:

☐ **Yes; I Consent** to receive services by secure video (e.g. telehealth).

☐ **No; I Do Not Consent** to receive services by secure video (e.g. telehealth). *In these instances, recommendations of in person services will provided at no cost to you.*

My signature below attests to the fact that:

- I have residency in either the state of New Mexico, Oregon, or Florida.
- I agree to participate in telehealth-based psychotherapy.
- I have read, understood, and agree to follow the above policies.
- I consent to having my electronic payment information stored on Ivy.

_____ _____
CLIENT SIGNATURE (REQUIRED FOR AGE 14+) DATE

_____ _____
PARENT / GUARDIAN SIGNATURE DATE

I have discussed this telehealth informed consent with the client(s) and/or their parent/guardian (if applicable). My observations of their behavior and responses give me reason to believe that this person is fully competent to give informed and willing consent. My signature below attests to this statement.

_____ _____
STEPHEN RATCLIFF, MA, LPCC (NM), LPC (OR), NCC, CST DATE