Pathways Counseling Center

7413 Maxtown Road
Westerville, Ohio 43082
614.818.4099
www.pathwayswesterville.com

Thanks for choosing Pathways! It is our hope and goal to make the coaching process as comfortable and helpful as possible.

You will find a checklist of documents below. Please take time to read and complete each document. You may address any questions or concerns at the time of your appointment. Please print the documents below, complete, and *bring them with you* to your first appointment. For online video appointments, please return the forms to our office by the day prior to your appointment.

- ☐ **Informed Consent Notice** (information and consent for treatment)
- ☐ **Client Financial Policy** (our financial agreement with you)
- ☐ **Credit Card Authorization**
- ☐ **Client Information form**
- ☐ **Health Questionnaire**
- ☐ **Notice of Privacy Practices** and **signature page** (how we comply with HIPAA laws)

Other forms that *may* be relevant (only complete if needed):

- ☐ **Authorization to Disclose Information** (if you would like me to coordinate care with your doctor, psychiatrist, pastor, or other)
- ☐ **Telehealth Informed Consent** (if we will conduct sessions via web-based video)

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Fax: 614.636.4944

Informed Consent Notice

Welcome to Pathways! Our goal is to provide you with quality care. As we begin, there are some things you need to know. Legally, this information is called "***Informed Consent***." It will help you understand what you can expect from Pathways, and some limitations.

The Difference Between Counseling and Coaching

Counselors diagnose and treat a wide range of issues, both clinical and non-clinical, including issues such as depression, anxiety, substance use, or relational issues. While counseling often focuses on deeper understanding, healing, and growth, coaching tends to be solution and goal driven, aiming to help a client to achieve their goals in the best possible way.

A coaching relationship focuses on clarifying goals and developing a plan to achieve them. Coaches do not diagnose, nor do they treat mental and emotional disorders. Should those needs surface in the course of a coaching relationship, a referral is made for professional assessment. Because no illness is involved, Coaches do not work with health insurance.

Meet Your Coaches

Bob and Linda Buchan work as Life Coaches at Pathways with a special focus on marriages and parenting. Bob received a B.A. from Otterbein University and then participated in a unique program that combined graduate education in counseling psychology from both Georgia State University (M.Ed.) and The Psychological Studies Institute. Later on, Bob completed another graduate degree in theology from International Seminary (M.Th.). Instead of becoming a licensed professional counselor, Bob worked in pastoral ministry for many years, most recently serving for over a decade as the Marriage & Family Pastor of Heritage.

Bob has been married to Linda since 1979, and they have been blessed with five children. Bob is also the author of the book, *First Love that Lasts*, published by Destiny Image, and he also created a helpful resource for individuals and groups called "*Following Jesus When You're Finding Work*."

Linda Buchan has served alongside her husband, Bob, in pastoral ministry for many years. She has extensive experience in working with individuals, couples and groups. Linda received a B.S. in Nutrition Education through Indiana University of Pennsylvania and is a certified Life Coach, having completed her education through the Institute of Life Coach Training.

Linda worked as a Life Coach at Beacon Center for Counseling and received training at Ashland Theological Seminary to lead "*Healing Care Groups*" that help people overcome the negative effects of past hurts. Linda also went through fifty hours of training to become a *Stephen Minister*.

Confidentiality

All of our work together (conversations, records, and any information that you give us) is protected by something called "***privilege***." That means the law protects you from having information about you given to anyone without your permission. At times, you may choose to allow us to disclose privileged information. This permission will be given in writing and you will specify what can be shared with whom. I will honor your privilege except in cases where breaking confidentiality is a professional or legal mandate, including the following:

1. *If we believe there is a risk that you might harm yourself or someone else*. If you are threatening to hurt yourself or someone else, I am obligated to do what I can to keep that from happening. This may include contacting a family member, civil authorities, or the intended victim, to give them the opportunity to protect you or themselves.
2. *If we have cause to believe that you are abusing children, elderly, or disabled people*. It is my duty to report actual or suspected child abuse or neglect. I am also obligated to notify the authorities in cases of abuse or neglect of vulnerable adults, including the elderly, infirmed, or mentally or physically disabled.
3. *In cases of a court order*. In the unlikely case that you become involved in a lawsuit, the court or lawyers may subpoena your information from us.

Our Office Policies

Coaching sessions are typically scheduled for 60 or 90 minutes, and we must end each session promptly.

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Future appointments are generally scheduled at the end of each coaching session.

Payment is expected at the time of your appointment. I accept credit/debit/HSA cards, cash or checks (made payable to "Pathways Counseling Center").

Regardless of your method of payment, we ask that you put a debit or credit card on file with our office. Card numbers are encrypted, and once entered, only the last 4 digits could be seen by Pathways staff. We reserve the right to charge that card for any balance that is accrued after 90 days of non-payment.

Returned checks must be resolved before any further appointments are scheduled. Our returned check fee is $35. We reserve the right to refuse personal checks and to require a different form of payment.

The following is the fee for coaching services:
$95 for each 60-minute session.
$150 for each 90-minute one.
Sliding scale fees are available on a limited basis, based on financial need. Typically, we do not charge for a phone consultation of 10 minutes or less.

The Pathways office telephone is answered 24 hours/day by an electronic answering system. During business hours (9am-5pm M-F), messages are checked regularly, and phone calls are returned the same day whenever possible. We do not check office messages on weekends or after 5pm on weekdays. If you have an emergency outside our scheduled office hours, please follow the instructions in the "emergencies" section of this form.

Please provide us with 24 hours notice if you need to cancel or reschedule an appointment. If you miss a scheduled appointment, it keeps other clients from benefitting from that opening, and a fee will be charged for the missed session or late cancellation.

If you have missed a scheduled appointment and you have no future scheduled visits and do not call our office within 10 business days, we will assume that you want to terminate this agreement and discontinue the coaching relationship.

Insurance companies do not pay for coaching appointments. For billing questions, please contact our administrator at 614.818.4099.

In the event of non-payment and attempts to communicate with the client yield no results, Pathways reserves the right to refer your case to a collections agency and the client is responsible for any additional costs associated with that process.

Emergencies

Pathways is not a 24-hour emergency facility. If a crisis situation should arise, please dial 911, go to the nearest hospital ER, or contact one of the following:

Franklin County Netcare, 614.276.2273
OSU Medical Center, 614.293.8333
Suicide Prevention Hotline, 800.273.8255
Delaware-Morrow Helpline, 211 or 800.684.2324

I have read this Informed Consent Notice and fee agreement. I understand it and agree to the terms described. I also understand that I may request a copy of this agreement if I choose to do so.

_____ _____ _____

Client name (please print) Client Signature Date

_____ _____

Bob and/or Linda Buchan Date

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FINANCIAL POLICY FOR COACHING SERVICES

Thank you for choosing Pathways Counseling Center! We are committed to your wellbeing and hope our services will help in your path to change, restoration, and healing. We recognize the need for clarity regarding billing and payments. The following is a statement of our financial policy, which all clients must read and sign prior to their first appointment.

INSURANCE COVERAGE

A coaching relationship focuses on clarifying goals and developing a plan to achieve them. Coaches do not diagnose, nor do they treat mental and emotional disorders. Should those needs surface in the course of a coaching relationship, a referral is made for professional assessment. Because no illness is involved, Coaches do not work with health insurance.

I understand that I am responsible for coaching fees, and that my health insurance will not cover these fees.

Initials _____

MISSED APPOINTMENTS

In order to provide the best possible service and availability to all our clients, we ask that you keep your appointments as scheduled. We understand that illness or other circumstances may occur, and we ask that you notify us as soon as possible if you need to cancel or reschedule an appointment. We require a minimum 24-hour notice to cancel or reschedule an appointment. If you miss an appointment or cancel with less than a 24-hour notice, you will be charged $95 or $150, depending on the length of the missed session. This fee must be paid before your next appointment.

I understand that I am responsible to pay any fees for missed sessions or late cancellations.

Initial _____

PAYMENTS

We ask that clients pay any charges due at time of service. We accept cash, check, HSA cards, most debit cards, and most major credit cards. Regardless of your method of payment, we ask that you put a credit or debit card on file for payments. Card numbers are encrypted and not visible to our office staff once entered. We reserve the right to use this card to pay any outstanding balance that may have accrued after 90 days. We will make a reasonable attempt to contact you before running your credit card for this purpose. Any returned checks are subject to a $35.00 fee. Returned checks must be resolved before any future appointments can be scheduled. We reserve the right to refuse any personal check and to require a different form of payment at our sole direction.

I understand that I am responsible to pay charges at time of service. If I accrue an unpaid balance, I understand that my credit card may be charged for this balance after 90 days.

Initial _____

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MINORS

Bob and Linda Buchan do not typically meet with unaccompanied minors.

CREDITS AND SMALL BALANCE WRITE-OFFS

Occasionally an overpayment is made, and a refund is due to the client. Credits will be applied to existing balances or future services already scheduled. If after 90 days a credit still exists and there are no future services scheduled, credit balances over $5.00 will be refunded. Similarly, any balance under $5.00 due to the practice will be written off after 90 days if no future services are scheduled.

ACCOUNT DELINQUENCY AND CREDIT REPORTING

Our office makes every reasonable effort to collect payment from insurance companies and clients. Once these efforts are exhausted, we may report unsatisfied accounts to a collection agency of our choice for payment and credit reporting. Before an account is sent to collections, any unearned adjustments may be reversed. Additional expenses, usually 35% of the amount sent to collections, are incurred for collection services, and this amount will be added to a client's balance. Unresolved accounts may be referred to court mediation. If you have an account that is referred to our external collection agency, your credit may be negatively affected.

I understand that if my account is sent to collections, I will incur additional expenses, usually 35% above my original balance due, and that it may negatively affect my credit rating.

Initials _____

I have read this financial policy and have had the opportunity to ask questions about it. I understand and agree to the financial policy.

_____	_____	_____
Client's Printed Name	Signature of Client or Responsible Party	Date

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Credit Card Authorization

I give permission for Pathways Counseling Center to use my credit card (information below) in payment of fees-for-service. This card is not authorized for any other use. This record will be destroyed or returned to me when coaching services are terminated.

Once entered, credit card information is encrypted and is unable to be seen by Pathways employees, except for the last 4 digits of the card number for identification purposes. I understand that I will receive an email notification any time my card is charged, to the email address I provide.

Credit Card Confirmation

_____
Name on card

_____ _____ _____ _____
Card Number

_____/_____ _____
Expiration MM/YY 3-digit code

_____ _____
Signature of responsible party Date

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CLIENT INFORMATION SHEET

Client Name: Last _____ First _____ Middle _____

Address _____ City, State, Zip _____

Phone: Mobile _____ Home _____ Work _____

Email address(es): _____

Gender: _____ Date of birth (MM/DD/YY): ___/___/___ Age: ____ Student? ❑ Yes ❑ No Grade: ____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Other _____

Permission to call & leave message at: ❑ Home ❑ Mobile ❑ Work ❑ Email ❑ Text ❑ Other _____

RESPONSIBLE PARTY FOR PAYMENTS ❑ Self ❑ Other (if someone other than you, please complete below)

(Note: If client is a minor and parents are separated or divorced, parent bringing the child is considered the responsible party for payments.)

Name: Last _____ First _____ Middle _____

Address _____ City, State, Zip _____

Phone: Mobile _____ Home _____ Work _____

Email address(es): _____

Gender: _____ Date of birth (MM/DD/YY): ___/___/___ Relationship to client: _____

EMERGENCY CONTACT

Full name: _____ Relationship to client: _____

Address _____ City, State, Zip _____

Phone: Mobile _____ Home _____ Work _____

Email address(es): _____

SIGNATURE(S)

I agree to pay for services in accordance with Pathways' Financial Policy. We request that payment for services be made at time of service. Your signature indicates financial responsibility for all balances due.

Client signature: _____ Date: _____

Financially responsible party: _____ Date: _____
(if different from client)

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HEALTH QUESTIONNAIRE

Client name: _____ Date of Birth (MM/DD/YY): ___/___/___

Do you have a primary care physician? ❑ yes ❑ no
Name & phone: _____

Do you have any physical impairments or limitations that may require special accommodations or arrangements that may affect our coaching sessions (e.g., reading difficulties, hearing loss, vision loss, speech impairment, etc.) ❑ yes ❑ no
If yes, please explain: _____

How would you describe the nutritional value and balance of your diet: ❑ good ❑ fair ❑ poor

Do you exercise regularly? ❑ yes ❑ no
Type & frequency: _____

Have you experienced any of these symptoms in the last 6 months? (please check all that apply)

❑ Headaches	❑ Compulsive behaviors	❑ Stomach/Bowel distress
❑ Depressed mood	❑ Anxious	❑ Excessive fears
❑ Crying	❑ Worry	❑ Periods of overactivity
❑ Guilt	❑ Nervousness	❑ Mood swings
❑ Sleep disturbance	❑ Change in appetite	❑ Eating problems
❑ Low self-esteem	❑ Social withdrawal	❑ Irritable/Temper
❑ Sad	❑ Change in energy	❑ Poor concentration
❑ Hopelessness	❑ Helplessness	❑ Apathy
❑ Obsessive thoughts	❑ Lack of pleasure	❑ Poor Memory
❑ Weight change	❑ Low motivation	❑ Substance abuse
❑ Sexual difficulty	❑ Suicidal thoughts	❑ Inability to function at work

Current/prior counseling

Are you currently taking prescribed medications for a mental health condition (e.g. depression, anxiety, etc.)? ❑ yes ❑ no List: _____
_____

Are you currently seeing a counselor, psychologist, or psychiatrist? ❑ yes ❑ no
Name: _____ Phone: _____
Focus of treatment: _____

Have you ever received counseling from a licensed mental health professional *in the past?* ❑ yes ❑ no
If so, who and when? _____
Focus of treatment? _____

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Trauma History

Have you ever experienced physical, sexual, or verbal/emotional abuse? ❑ yes ❑ no
Please elaborate: _____

Have you ever been traumatized by a difficult life event? ❑ yes ❑ no
Please elaborate: _____

Have you ever attempted to harm yourself or take your own life? ❑ yes ❑ no
Please elaborate: _____

Have you ever had substance use issues (e.g. alcohol, prescription meds, other drugs)? ❑ yes ❑ no
Please elaborate: _____

Has anyone in your family had substance use issues? ❑ yes ❑ no

Spiritual History

Is faith in God important to you? ❑ yes ❑ no
Do you regularly attend worship services with others? ❑ yes ❑ no
Do you practice spiritual disciplines such as prayer, reading, and journaling? ❑ yes ❑ no
Do you serve in any type of ministry ❑ yes ❑ no
Are you involved in a small group to support you in your journey? ❑ yes ❑ no
Do you have a mentor to help you grow? ❑ yes ❑ no

Marital and Family History

Is there a history of emotional/mental health problems or suicide in your family? ❑ yes ❑ no
Please elaborate: _____

Number of siblings: _____ Relationship with siblings: _____

Describe relationship with your parents: _____

Spouse's name: _____ Years married: _____

Number of previous marriages: ____ Reasons for divorce: _____

_____

_____

Children's names and ages _____

_____

_____

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Marital Ratings

Describe the current status of your marriage from 1-10, with 1 being worst and 10 being best:

Quality of communication
1……..2……3……4……5……6……7……8……9……10

Ability to resolve conflicts
1……..2……3……4……5……6……7……8……9……10

Agreement on finances
1……..2……3……4……5……6……7……8……9……10

Sexual satisfaction
1……..2……3……4……5……6……7……8……9……10

Work-life balance
1……..2……3……4……5……6……7……8……9……10

Quality time together
1……..2……3……4……5……6……7……8……9……10

Closeness
1……..2……3……4……5……6……7……8……9……10

Trust in each other
1……..2……3……4……5……6……7……8……9……10

Respect for each other
1……..2……3……4……5……6……7……8……9……10

Unity and consistency in parenting (if applicable)
1……..2……3……4……5……6……7……8……9……10

The information I have provided above is true to the best of my knowledge.

_____ _____

Client Signature Date

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

This notice describes the privacy practices of Pathways Counseling Center (hereinafter referred to as PCC). This notice applies to all of the health records that identify you and the care you receive from us. If you are under 18 years of age, your parents or guardian must sign for you and handle your privacy rights for you.

PRIVACY AND THE LAW

PCC is required to give you this Notice of Privacy Policy because of federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We will follow the terms of this notice while it is in effect and inform you of any changes. PCC is committed to keeping your information private, and we are also required by law to respect your confidentiality.

WHO WILL FOLLOW THIS NOTICE

Any professional authorized to enter information into your record, all employees, staff and other personnel at PCC who may need access to your information must abide by this Notice of Privacy Practices. All business associates (such as our billing electronic claims submission service and credit card submission for this practice) may share information with each other for payment purposes and to complete services. Only the minimum necessary information needed to accomplish the task will be shared.

PROTECTED HEALTH INFORMATION (PHI)

Any information we collect in our sessions is Protected Health Information (PHI). Information we receive may be stored as paper charts and files, or computer and electronic data.

USE AND DISCLOSURE OF PHI

Use. Use of PHI occurs when your information is read by approved Pathways personnel for routine purposes (e.g. billing).
Disclosure. Disclosure of PHI occurs when you give your consent to share your information with others. For example, when being referred to a professional counselor, you may want us to send information to that individual or individuals.
Consent Form. By law, we may not treat you unless you give us written authorization to use your PHI for the purposes of treatment, payment, and healthcare operations. We may use and disclose this information without your specific consent.

Treatment. We may use and disclose your PHI to provide, coordinate, or manage your mental health care and related services, for example, if we consult with other health care providers regarding your treatment with us, or if we refer you to another professional such as a physician or psychiatrist, for additional services.
Payment. We may use and disclose your PHI to bill you. We may also disclose limited PHI to consumer reporting agencies related to collection of payments owed to us.
Healthcare Operations. We may use or disclose your PHI for mental health care operations to ensure that you receive quality care. For example, to review our treatment and services and to evaluate the performance of our staff as it relates to your care.

APPOINTMENT REMINDERS

Ways we may contact you include, but are not limited to, voice mail messages, postcards, letters and email, or text messages, unless you direct us otherwise in writing.

OTHER USES AND DISCLOSURES NOT REQUIRING CONSENT OR AUTHORIZATION

The law lets us use and disclose some of your PHI without your consent or authorization, when required by law. There are some federal, state or local laws, which require us to disclose PHI. By law we are required to report:

- Suspected child and elder abuse or neglect
- Abuse or neglect of an incompetent adult (such as a severely mentally retarded adult)
- Incidents of domestic violence

If you are involved in a lawsuit or legal proceeding and we receive a subpoena, discovery request, or other lawful process, we may have to release some of your PHI. We will only do so after attempting to inform you of the request, or perhaps after consulting your lawyer, or trying to get a court order to protect the information requested. ***For Law Enforcement Purposes.*** We may release PHI if asked to do so by a law enforcement official to investigate a crime or criminal. ***For Public Health Activities.*** We may disclose PHI to agencies that investigate for purposes related to preventing or controlling disease, injury, or disability. ***For Specific Government Functions.*** We may disclose PHI if you are an inmate, and for national security reasons. ***To Prevent a Serious Threat to Health and Safety.*** If we believe that there is a serious threat to your health or safety, or that of another person, or of the public, we can

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disclose some of your PHI. We will only disclose to persons who can prevent the danger.

USES AND DISCLOSURES TO WHICH YOU HAVE AN OPPORTUNITY TO OBJECT

With your permission, we may share your PHI with medical providers, family, or others involved in your care, such as close friends or clergy. You may inform us whom you wish us to contact, and the limits of what we may share. We will honor your wishes as long as your request is not against the law. In an emergency, we may share information if we believe it is what you would have wanted and is in your best interest. We will tell you as soon as possible of the action we have taken. We will discontinue such action at your request as long as it is not against the law.

YOUR PERSONAL HEALTH INFORMATION RIGHTS

Right to Request Restrictions. You may submit a written request indicating the PHI about which you wish to restrict disclosure. We are not required to agree with your request, but we will do so if we are able (e.g., if it is not against the law).
Right to an Accounting of Disclosures. When we disclose your PHI, we record to whom it was sent, when and what was sent. You may submit a written request for a list of these disclosures. You must state the time period of disclosures you are requesting (no longer than 6 years and may not include dates prior to April 14, 2003).
Right to Amend. You may request in writing an amendment to your PHI that is incorrect or incomplete, indicating the reason supporting your request. If we deny your request, you have the right to file a statement of disagreement with PCC. Such statements and our rebuttal will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.
Right to Inspect and Copy. You may make a written request to inspect and copy your PHI. We may deny your request in limited circumstances, including coaching notes, information for use in civil, criminal and administrative action, and PHI to which access is prohibited by law. If we deny access, you may request the denial be reviewed by another licensed mental health professional. PCC reserves

the right to charge a fee for the costs of copying, mailing, or other supplies associated with your request.
Right to Request Confidential Communication. You may specify in writing how or where you wish to be contacted by PCC regarding the confidential communication of your PHI. You do not need to give us a reason for such a request. We will accommodate all reasonable requests, but we reserve the right to deny those that impose an unreasonable burden on the practice.
Right to a Paper Copy of this Notice. If you have agreed to receive this Notice of our Privacy Practices electronically, you may request a paper copy.

USES AND DISCLOSURES THAT YOU AUTHORIZE

If you need more information or have questions about our privacy practices, please speak to the Privacy Officer whose name and telephone number appear below. If you have a problem with how your PHI has been handled, or if you believe your privacy rights have been violated, contact the Privacy Officer. You have the right to file a complaint with PCC and with the Secretary of the Federal Department of Health and Human Services. We promise that we will not in any way limit your care at PCC or take any actions against you if you file a complaint.

US Department of Health and Human Services
233 N Michigan Ave, Suite 240, Chicago, IL 60601
312.886.2359

Office for Civil Rights Department of Health and Human Services
Mils Stop Room 506F
Hubert H Humphrey Building
200 Independence Ave SW, Washington, DC 20201
202.205.8725

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Effective September 1, 2006

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Acknowledgement of Receipt of Notice of Privacy Practices

This is to acknowledge that I have read Pathways Counseling Center's Notice of Privacy Practices (effective September 1, 2006) on the date below and can request a copy to take with me if I would like to do so.

_____
Client name (please print)

_____ _____ _____
Client street address (please print) City, State Zip Code

_____ _____
Client signature Date
(or personal representative's signature)

_____
Name of personal representative (if applicable)

_____
Description of representative's authority to act for the client (if applicable)

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Authorization to Use and Disclose Protected Health Information

I am completing this form to allow the use and sharing of protected health information about:

Printed name: _____ Date of Birth: _____

The above person authorizes **Bob or Linda Buchan** of Pathways Counseling Center, to use, disclose, and provide information to the following individual(s) and/or agency

Name(s): _____

Address: _____ Phone/fax: _____

concerning their evaluation, treatment, or contact with:

_____
(clients' names -- include children's names if applicable)

This authorization for the release of information includes, but is not limited to, coaching notes and any records that may have been kept in the course of the client's evaluation and coaching sessions. The information may be released by **Bob or Linda Buchan,** in written form, as copies of existing records, or be a written or verbal report, either in person or by telephone, and may be sent through the mail or provided by fax transmission. A photocopy of this signed release waiver is considered as valid as the original.

After the expiration of this authorization, no more of this information can be used or released to the individual or agency unless I sign a new authorization. I understand that I can revoke or cancel this authorization at any time. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date. I understand that I may inspect and have a copy of the information described in this authorization. I understand that if the individual or agency that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

I affirm that everything in this form that was not clear to me has been explained, and I now understand all of it. The undersigned has the authority to allow the release of information concerning the persons named above. This release waiver becomes effective on _____, and is to remain in effect until _____, or until cancelled by written notification to **Bob or Linda Buchan,** signed by the client or the client's legal representative.

_____ _____ _____
Authorized person's name (please print) Authorized person's signature Date

I have discussed the issues above with the client and/or their representative. My observations of their behavior and responses give me no reason to believe that they are not competent to give informed and willing consent.

_____ _____
Bob and/or Linda Buchan Date

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INFORMED CONSENT FOR TELEHEALTH SERVICES

PURPOSE

The purpose of this form is to obtain your consent to participate in telehealth services. Telehealth is the delivery of coaching services using interactive technologies (audio, video, or other electronic communications) between you and your Life Coach.

NATURE OF TELEHEALTH SESSION

I understand that we will conduct telehealth sessions as we would a face-to-face sessions, using a HIPAA-compliant and secure telecommunication service to protect the confidentiality of any information transmitted. No video, audio, and/or photo recordings will occur during sessions.

PAYMENT

I understand that the payment agreement I signed for coaching services also applies to telehealth.

RISKS OF TECHNOLOGY

I understand there are inherent risks with telehealth that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

EMERGENCIES

I understand that if an emergency arises, it is my responsibility to call 911 or go to my nearest emergency room.

MENTAL HEALTH INFORMATION & RECORDS

I understand that all existing laws regarding my access to mental health and personal information also apply to telehealth.

CONFIDENTIALITY

I understand that reasonable and appropriate efforts have been made to eliminate confidentiality risks associated with telehealth sessions, and all existing protections under federal and Ohio state law apply to information disclosed during telehealth sessions. To ensure my privacy and confidentiality, I will participate in the session in a private space that is free from distractions and other parties.

RIGHTS

I understand I may withdraw consent to telehealth services at any time by notifying my Life Coach in writing.

IDENTITY VERFICATION

At the beginning of each telehealth session, I am willing to provide the Life Coach my full name and date of birth to confirm my identity, along with the address of my current location.

I agree that I have been advised of potential risks, consequences, and benefits of telehealth. I have had the opportunity to ask questions about the information on this form and telehealth services. My questions have been answered, and I understand and agree with the information on this form.

_____	_____	_____
Name (printed)	Signature	Date