Welcome to Agape Therapy Services Therapy Services! Thank you for choosing Agape Therapy Services Therapy Services to help meet your speech and language pathology needs. We realize there are many options from which to choose, and we appreciate the opportunity to assist you during this important process. Please fill out and return the following documents:

___ Pediatric Intake Form
___ Payment Policy and Agreement (Private-Pay Clients)
___ Assignment of Benefits (Insurance Clients)
___ Attendance Policy
___ Authorization for Release and Exchange of Information
___ Media Consent Form
___ Therapy Agreement
___ Informed Consent for Speech-Language Therapy
___ Client Notification of Privacy Policies (HIPAA Authorization)
___ Privacy Notice Acknowledgement
___ Telepractice Consent Form

To proceed with scheduling of services, please fill out and complete the forms indicated above and return them to: Agape Therapy Services Therapy Services, LLC Attn: Leasonna Boozer-Fuller. Fax #: 1(210) 890-8988 or lfuller@agapetherapyservices.com.

If your child has had any recent evaluations completed by other health professionals (psychologist, ENT, Oncologist, Gastroenterologist etc.), please bring copies of these with you or you may email them in advance at this email address: lfuller@agapetherapyservices.com.

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Pediatric Intake Form

GENERAL INFORMATION

Please provide the following information. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Child's Name: ___________________________ Today's Date: ___________________
Child's age: _____________________________ Date of Birth (DOB): _____________
Child's gender (please check): Male ____ Female ____
Address:____
____
__

Parent/Guardian's Name:
____

Parent/Guardian's Name:
____

Home phone: ____May I leave a message? Yes No
Cell phone: ____May I leave a message? Yes No
Work phone: ____May I leave a message? Yes No
Email: ____May I email you? Yes No

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(For appointment scheduling purposes only, as email is not considered a confidential medium of communication).

Doctor's Name: ____

Doctor's Phone Number: ________________________

INSURANCE/PAYMENT INFORMATION:

Primary Insured: __________________________ DOB: ___________

Primary Insurance Carrier: ____

Phone Number: ___________________

Billing/Claim Address: ____

City: ______________________ State:________

ID #: ___________________________Group #: ________________________

Secondary Insurance: ____

Policyholder Name: ___________________________________ DOB: ________

Phone Number: ________________

Billing/ClaimAddress:____

City:_________________________ State:__________

Policy Group or #: ____________________ Group #: ______________

REFERRAL INFORMATION AND PRESENTING CONCERNS

Who referred your child to my private practice? Please provide agency/professional's name & telephone #:

____

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May I contact the agency/person to thank them for referring you? (Please circle) Yes No
Please initial: _______

What is the main reason(s) you're seeking help for your child? (Include how long he/she's had these symptoms or problems):

____
____
____

What are your hopes regarding your child's therapy?

____
____
____

MEDICAL INFORMATION

Does your child currently have any medical problems? ______________________________

____
____
____

Has your child ever been treated for any of the following? If so please circle and describe below:

Head injury or loss of consciousness Meningitis Tonsils/Adenoids Thumb sucking

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Frequent ear infections   Seizures   Vision Problems

Sleeping difficulties   Tubes placed in ears   Asthma

Flu   Sinusitis   Mumps

Hearing or vision problems   Allergies   Measles

____

____

____

____

Has your child previously seen a speech-language pathologist? If so, what year? Who did he/she see and for what reason? Was the experience helpful or not? How so?

____

____

____

____

Has your child ever been hospitalized? If so, list when, where, & reason:

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____
__
____
__
____
__
____
__

Does your child have any problems seeing? _______ Wears glasses? __________

Is your child receiving orthodontic treatment? (circle) Yes   No. If yes, please describe procedure and date of start of services: ____
____
_
____
_

Please list your child's current prescription medications with dosage (psychiatric and general health): ____
____
_
____
_

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When was your child's last complete physical exam (month/year)?______________________

Has your child participated in a hearing screening? (circle) Yes No
If yes, what were the results?____

Is your child presently being treated by a(n):
Pediatrician? ______ ENT? ______ Psychologist? ______

Neurologist? ______ Physical Therapist? ______ Occupational Therapist? ______

CHILD'S FAMILY

	Biological Mother	Biological Father
Current age, (or if deceased, please include date, age, & cause of death)		

Country of Origin		
Occupation		
Highest grade completed		
Any history of the following (please circle)	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse

Parents are (choose one): Married Separated Divorced Living Together

If separated or divorced, how old was your child when the separation occurred?

____

Child lives with (choose one): Both parents Mother Father Other

Who has legal custody?

____

Please describe the current visitation schedule (if any) and type of communication with child's other parent:

____

____

Siblings Please list your child's brothers and sisters in the order of birth (including adopted or step siblings), current age, grade, and whether the sibling lives in the home.

____
____
____
____

CHILD'S BEHAVIORAL CHARACTERISTICS

Please circle____

Cooperative Yes No
Attentive Yes No
Willing to try new activities Yes No
Plays alone for reasonable length of time Yes No
Separation difficulties Yes No

Easily frustrated/impulsive Yes No
Stubborn Yes No
Restless Yes No
Poor eye contact Yes No
Easily distracted/short attention Yes No
Destructive/Aggressive Yes No
Withdrawn Yes No
Inappropriate Behavior Yes No
Self-abusive behavior (biting, slapping, etc) Yes No

CHILD'S DEVELOPMENTAL HISTORY

Pregnancy and Birth Length of pregnancy (months) ______
Where there any complications during pregnancy (high blood pressure, diabetes, hospitalization): If so, please describe:

____
Type of Delivery (check one) Vaginal _________ Caesarian _________ (if yes, reason):

____
Medications used during pregnancy? Please list: ______________________________
Smoking? Yes No How much? ______________________________
Alcohol intake? Yes No How much? __________________________
Drug intake? Yes No How much? ____________________________
Length of pregnancy? ____Weeks Age of mother at birth:_______ Birth weight: _______
Were there any complications during delivery (trouble breathing after birth, cord wrapped around neck, etc)? If so, please describe:

____

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____

Length of stay in the hospital? Mother: ________(days)   Child: __________(days)

Developmental Milestones and Early Development

At what age did your child do the following (indicate approximate month or year of age for each):
Babble ______Crawl______ Sit Alone_______ Stand Alone_______ Walk Alone_______

Said First Words______   Put Multiple Words Together________   Feed Self ________

Speak in Short Sentences __________ Learn to Use the Bathroom Alone (toilet trained)
____

Did/does your child choke on foods or liquids? _____ If yes, which foods/liquids?
____
_ Did/does your child frequently put items in his/her mouth? ___________
Did/does your child suck fingers or thumbs? _________________
Is your child a picky eater? ____________________
Was your child (check one): Bottle fed _____ Breast Fed _____
Age weaned from bottle/breast: _____
If your child has siblings, was development different in any way?
Explain:____
____
____

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CHILD'S SCHOOL, COMMUNICATIVE, HOME, SOCIAL & PERSONAL FUNCTIONING

School/Academics Your child's current grade? _________Has he/she ever repeated a grade? Yes No If so, which? _________
School name: ____Public or Private? (circle one) Street Address: ____
School District/County? ____________________________________
Phone: ____________________
What preschool experience did you child have?
____
____

Where any problems detected in your child's kindergarten screening? Yes No If so, please explain: ____
____
Is your child in a general education classroom? Yes No
Does your child have an IEP ? Yes No
Has your child ever received tutoring? Yes No If so, please explain:
____
____
____What are your child's typical grades? ______________________

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What are your child's strongest and weakest points academically? ________________________
____
____
____

Are you satisfied with your child's educational program? (circle) Yes No
Please explain: ____
____
____

Communicative Function

Do you feel your child has a communication problem? If so, describe: ____________________
____
____
____

Do you feel your child has a hearing problem? If so, describe: ___________________________
____
____
____

How does your child communicate primarily? Please circle: Gestures (pointing, nodding, etc)
Single Words Multiple Words/Phrases Complete Sentences
Does your child get frustrated by his/her difficulty or inability to communicate? _______If yes, describe: ____
____

____
____

If your child talks now, can you understand? Can family members? Can strangers? Explain:
____
____
____
____
____
____

Social and Community Engagement What are your child's favorite activities or hobbies?
____
____
____
____
____
____

In what extracurricular/community activities is he/she involved?
____
____
____
____
____

How does your child get along with other children?
____
____
____
______

Please provide any additional information which you would like me to know or which you feel would be helpful to better understand your child:
____
____
____
____
____
____

PAYMENT POLICY AND AGREEMENT (Private Pay Clients)

Thank you for choosing Agape Therapy Services as your service provider. We are happy to provide therapy services for you and your family. Please indicate the service requested and the method of payment below:

Evaluation Services
____ The private pay rate of $200 for a 2-hour Pediatric Speech-Language evaluation will be charged to me. Payment is accepted in the form of cash, check, or debit/credit card. I am also responsible for these payments at the time of my visit.

Group Therapy Services (Teen Social Skills Groups)
_____The private pay rate of $85 per 60-minute therapy session will be charged to me. Payment is accepted in the form of cash, check, or debit/credit card. I am also responsible for these payments at the time of my visit. IEP

Consultations/Advocacy Services
__The pay rate of $30 per 30-minute IEP consultations via telephone or in-person will be charged to me. Payment is accepted in the form of cash, check, or debit/credit card. I am also responsible for these payments at the time of the scheduled appointment.

OR

__The pay rate of $60 per hour for IEP advocate services will be charged to me. This service includes the SLP attending your child's IEP meeting and serving as a consultant to ensure your concerns as a parent is being addressed in the IEP process. I am also responsible for these payments at the time of the scheduled appointment.

I AGREE AND ACCEPT THE ABOVE TERMS AND SERVICE AGREEMENTS.

_______________________________________ ____________________
Client/Guardian Signature Date

____
Client's Name (please print)

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ASSIGNMENT OF BENEFITS (Insurance Clients)

***As a courtesy, we will verify your insurance benefits. However due to continuous inconsistent information provided by insurance companies, verification is NOT a guarantee of payment. Payment is ultimately the responsibility of the patient/guarantor. ***

I, ____________________________________, authorize the release of any payment and medical information necessary to process myself or my family member's insurance claim and related claims. I hereby authorize payment directly to LBF Speech Communication Consulting Services, PLLC of the insurance benefits otherwise payable to me for all professional services.

Signature of Policyholder:
____Date:_______________

PARTY RESPONSIBLE FOR PAYMENT

Name: ____________________________________ DOB: _________________

SSN: ________________________

Address ____________________________________ Phone:
______________________________ Employer

Name:_____________________________________Phone:_____________________________

Employer Address:
____

______I have read and understand the payment policy. (Please Initial)

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PHOTOCOPY AUTHORIZATION

I permit a photocopy of this consent form as if it were an original executed consent.

Name of Client (Printed): _______________________________ Date: ___________________

By signing below, you are attesting to the accuracy of the above statements including all consents and authorizations implied therein. A copy of this agreement is available upon request.

Client Signature: _______________________________
Date____________________

Legal Guardian (if applicable) Signature: __________________________ Date: _______________

ATTENDANCE POLICY

Agape Therapy Services strives to ensure each client receives the services that best fit his/her needs and that progress is being made in therapy. Regular attendance at therapy sessions is imperative in achieving this goal. Therefore, Agape Therapy Services has the following policies regarding attendance:

I understand that a $40.00 fee may be charged for “no shows” and for cancellations made less than 24 hours before a scheduled appointment. I will receive notification of this fee via e-mail. If this fee is not paid in full within seven (7) days, my services will be put on hold until payment is received. I understand that this fee is not billable to any funding source and that this fee must be paid in order to continue services. _____ **Initials**

I understand that if I miss three (3) consecutive sessions (with the exception of serious illnesses or emergencies), I will be notified that I am in jeopardy of losing my appointment slot, and it may be given to someone else. _____**Initials**

I understand that if I miss a total of three (3) consecutive or non-consecutive sessions without calling 24 hours in advance to cancel the sessions (with the exception of serious illnesses or

emergencies), I will be removed from my scheduled appointment slot and charged with cancellation fees for those sessions.

I understand that if I plan to go on a vacation and will be absent for two (2) or more weeks, I must notify the therapist at least a week in advance so that efforts can be made to reschedule my appointments. _____**Initials**
I understand if I am late to an appointment, the session will need to conclude at the usual time to allow the therapist to remain on schedule. If the therapist is running late for any reason, I will be given my full session time. Our staff regrets any inconvenience to our personal schedule, and we will make our best efforts to maintain timeliness. _____**Initials**

It is the responsibility of the client and the therapist to be respectful of health concerns. Clients who are sick should not be seen for therapy and therapists who are sick will not provide services to avoid spreading illness. If you are showing symptoms of illness on the day of an appointment or has exhibited vomiting and/or fever within the last 24 hours, please contact our office as soon as possible. Should the therapist become ill, you will be contacted to reschedule the appointment. _____**Initials**

Agape Therapy Services reserves the right to cancel or reschedule appointments in the event of inclement weather. Our goal is to keep our therapists safe on the roads. Many clients keep the same appointment time each week, in which case it is understood that you will be seen at the same time on the following week. _____**Initials**

____ _______________
Client/Guardian Signature Date

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____
Client's Name (please print)

AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

I hereby request and authorize the release and exchange of any relevant written or verbal medical, social, psychological, and/or test information you may have pertaining to:

___________________________ ________________ _________________________

Client Name Date of Birth Legal Representative

The disclosure of this information is requested for the following purpose(s): ____

Release To:
Agency Name: ______________________
Attention: ____________________
Street Address: _____________________
Address:______________________ _________________________ ______________________
Phone: ___________________

Release From:
Agency Name: _____________________
Attention: _____________________
Street
Phone:__________________

I understand that this consent is valid for one year from the date of signing and that I may revoke this consent at any time, by notification in writing to either of the named agencies. This revocation shall apply to both agencies except to the extent of action that has already been

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taken. I further release the agencies/persons and their associates from any liability arising from the release of this information or records to such designated persons or agencies.

______________________________ ___________________________ ___________

Client/Legal Representative Signature/Relationship Date

MEDIA CONSENT

Dear Clients,
We are updating our website and would like to include photos of our current clients while they are engaged in therapy sessions. Please read and sign below to grant LBF Speech Communication Consulting Services,PLLC the right to use photos of you for educational, therapeutic, or promotional reasons. I hereby grant full permission to LBF Speech Communication Consulting Services,PLLC to use my photograph in the following publication or advertising materials (printed or electronic, please circle):

- Website
- Posters
- Brochure
- In-house educational purposes
- Interdisciplinary Collaboration/Educational Purposes
- Any and all
- None

___________________________________ _________________

Client's Name Date

____ _________________

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Authorizing Guardian's Name (Please Print) Relationship to Client

____

Authorizing Signature

THERAPY AGREEMENTS

Therapy Sessions Therapy sessions are 30-60 minutes in length for all clients. If applicable and/or appropriate, caregivers will be called into the room to speak with the clinician about the client's progress and homework during the last 5-10 minutes of the session. This is an important part of the treatment session as the client's progress is contingent upon the practice and carry-over that occurs in the home setting.
_____**Initials**

If you have specific questions, issues, or concerns that you would like to address, please let the clinician know at the beginning of the session, so that the proper amount of time can be allotted to speak with you. If you do not notify the clinician at the start of the session that you are requesting additional time for questions, the clinician will have to address your questions at the next session. The clinician appreciates your understanding and compliance in helping us maintain timeliness for all of our scheduled appointments. _____**Initials**

Termination of Therapy The following reasons may be a cause to terminate our client contract:
• Behavior of a client (e.g., refusing to engage in therapy, refusing to follow directions or recommendations, verbal abuse, etc.). We anticipate and understand that all clients have "bad days,"; however, if the behavior is on-going, we may recommend a change in clinician. If the

behaviors continue to persist after that point despite a variety of strategies implemented by the clinician(s), you will be referred to another facility
• Behavior of a caregiver
• Non-compliance with our attendance policy
• Repeatedly not paying your account balance. You will receive a warning when there is an outstanding account balance with multiple payments due. If we do not receive your payment within 7 days upon receipt of that warning, therapy will be placed on hold until payments are rendered in full. You may lose your appointment slot and be placed on a waiting list at that time. Continued non-payments will result in termination of services.
• Engaging in behavior that breaches trust such as withholding pertinent information about the case history or asking us to alter our data or diagnosis.

If you need to terminate therapy for any reason, we ask that you give us written notice a minimum of two (2) sessions in advance. This will allow us adequate time to wrap-up therapy and complete a consultation with you. A therapy termination form will be provided for you to complete. _____**Initials**

LBF Speech Communication Consulting Services,PLLC reserves the right to cancel or amend this contract, or any part therein without negating the remainder of the contract. Clients will be notified, in writing, of any changes or cancellation of this contract. _____**Initials**

I have read and accept the terms of this contract.

Signed this ______ day of ___________________, _________.
(day) (month) (year)

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________________________________	________________________________
Leasonna Boozer-Fuller, M.A., CCC-SLP Owner, Speech-Language Pathologist Client/Guardian	Client/Guardian Signature

INFORMED CONSENT FOR SPEECH-LANGUAGE THERAPY

I, ________________________________, the client hereby request and consent to LBF Speech Communication Consulting Services, PLLC to perform a screening and/or an evaluation and treat my disorder as prescribed by a physician and/or recommended by a speech-language pathologist.

I understand and I am informed that, as in the practice of medicine, speech, language, and feeding/swallowing therapy may have some risks. I understand that I have the right to ask about these risks and have any questions answered about my condition, prior to treatment.

I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss it with the treating therapist.

I consent and authorize LBF Speech Communication Consulting Services, PLLC to administer treatment under the direction and supervision of a certified speech-language pathologist.

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__________________________________ ________________________

Signature of Client Date

CLIENT NOTIFICATION OF PRIVACY POLICIES (HIPAA Authorization)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Speaking of the Matter Therapy Services, LLC is dedicated to ensuring the privacy of your speech-language evaluation results and the course of therapy treatment. In serving our patients, we create records regarding treatment and services that are provided in order to have accurate information and to ensure the appropriateness and efficiency of treatment services. Federal law requires us to strictly protect any personally identifying information of yours. This notice discloses our policies regarding the storage, use, and sharing of confidential patient information. PLEASE REVIEW THIS NOTICE CAREFULLY.

LBF Speech Communication Consulting Services, PLLC is required by law to keep your health information safe. This information may include:

· Notes from your doctor, teacher, or other health care provider
· Your medical history
· Your test results
· Treatment notes
· Insurance information

A government rule requires that you get a copy of this privacy notice. This rule is called the Health Insurance Portability and Accountability Act, or HIPPA for short. We will ask you to sign a paper acknowledging that you have been given this notice.

How Your Health Information May Be Used or Shared
We may use or share your health information for the following purposes:
1. **Treatment**: We may share your information with doctors or other health care providers who care for you. For example, if your doctor orders speech therapy, we will share the results of our treatment with that doctor.
2. **Payment**: We may use and share information about the treatment you receive with your insurance company or other payer to receive payment for therapy services. This may include sharing important medical information. We may share your information to: a) Receive the insurance company's permission to start treatment b) Receive permission for more treatment c) Receive compensation for the treatment you receive

Your health information may be used or shared without your permission for the following:
· **Abuse and Neglect**: We may share your health information with government agencies when there is evidence of abuse, neglect, or domestic violence.
· **As Required by Law:** We will share your information when we are told to by federal, state or local law. We will also share information if we are asked by the police or courts.
· **Government Functions**: Your information may be shared for national security or military purposes. If you are a veteran, your information may be shared with the Office of Veteran's Affairs.
· **Information About a Person Who Has Died**: We may share information with the coroner, medical examiner, or a funeral director, as needed.
· **Health-Related Benefits and Services**: We may use your information to let you know of other services that might be of interest to you.

· **Public Health Risks**: We may report information to public health agencies as required by law. This may be done to help prevent disease, injury, or disability. It may also be done to report medical device safety issues to the Food and Drug Administration and to report diseases and infections.
· **Regulatory Oversight**: We may use or share your information to report to agencies overseeing health care. This may include sharing information for audits, licensure, and inspections.
· **Threats to Health and Safety**: Your health information may be shared if it is believed that it will prevent a threat to your health and safety or the health and safety of others.

When Your Permission is Needed to Use or Share Your Health Information
You must give us your permission to use or share your health information for any situation that is not listed on this notice. You will be asked to sign a form, called an authorization, to allow us to share your information. You are allowed to take back this authorization, called revoking authorization, at any time. We will not be able to get the information back that we shared with your permission.

Your Privacy Rights
You have the right to:
· **Ask us not to share your information**: You can ask us not to use or share your information for treatment, payment, or health care operations. You can also ask us not to share information with people involved in your care, like family members or friends. You must ask for limits in writing. We must share information when required by law. We do not have to agree to what you ask.
· **Ask us to contact you privately**: You can ask us to only contact you in a certain way or at a certain place. For example, you may want us to call you but not email. Or you may want us to call you at work and not at home. You must ask in writing.
· **Look at and copy your health information**: You have the right to see your health information and get a copy of that information at any time. You have the right to see treatment, medical, and billing

information. You may not be able to see or copy information put together for a court case, certain lab results, and copyrighted materials, such as test protocols.
· **Ask for changes to your health information**: You can ask us to change information that you think is wrong. You can also ask that we add information that is missing. You must ask us in writing and give us a reason for the change. We do not have to make the change.

· **Get a report of how and when your information was used or shared**: You can ask us to tell you when your information was shared and who we shared it with. There are some rules about this: o You need to ask us in writing. o You must tell us the dates you are asking about and if you want a paper or electronic copy.
· **Get a paper copy of this privacy notice**: You can get a paper copy of this notice at any time.
· **File complaints**: You can file a complaint with us or with the government if you think that a) Your information was used or shared in a way that is not allowed; b) You were not allowed to look at or copy your information; c) Any of your rights were denied

Who is C**overed by This Notice**
The people that must follow the rules of this notice are:
· All Speech-Language Pathologists at LBF Speech Communication Consulting Services, PLLC
· Anyone who is allowed to add health information to your file, including students and other staff
· Any volunteers who may help you while you are at this clinic/private practice

Changes to the Information in This Notice
We may change this notice at any time. Changes may apply to information we already have in your file and any new information. Copies of the new notice will be available from our staff. The notice will have a date on the front page to tell you when it went into effect.

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Complaints
You may file a complaint if you think we did something wrong with your information. You can complain to your regional office of the United States Office of Civil Rights. All complaints must be in writing. You will not get in trouble for filing a complaint.

Contacts If you have any other questions about this notice or your privacy rights, please ask your Speech-Language Pathologist.

I HAVE READ AND UNDERSTAND THE PRIVACY POLICIES DISCLOSED IN THIS NOTICE.

________________________________ _______________________
Client/Guardian Signature Date

PRIVACY NOTICE ACKNOWLEDGMENT

LBF Speech Communication Consulting Services, PLLC is required by law to keep your health information safe. This information may include:

· Notes from your doctor
· Your medical history
· Your test results
· Treatment notes

We are required by law to give you a copy of your privacy notice. Please retain a copy of this privacy notice for your records. This notice tells you how your health information may be used or shared. It also tells you how you can look at and comment on your information. By signing this page, you are saying that you have been given a copy of our privacy notice.

Client Name: ____

Client D.O.B: ____

Guardian Name: ____

Guardian Signature: ____

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Date: ____

TELETHERAPY CONSENT FORM

The American Speech and Hearing Association (ASHA) defines telepractice (the act of providing Telehealth services) as "the application of telecommunications technology to delivery of professional services at a distance by linking clinician to client, or clinician to clinician, for assessment, intervention, and/or consultation." This means that we are able to provide speech therapy services through digital meetings similar to the popular communication system “Skype”. While we do not specifically utilize skype for the provision of services, the method of delivery would be similar in nature. The therapist and the child would join a computer based session at the designated therapy time, and would work on the same materials as in the office. We term this “teletherapy.” It is important to know that this service delivery model is supported through the Virginia licensing board, the American Speech-LanguageHearing Association (ASHA), and is payable by most insurance carriers per the Telehealth Enhancement Act of 2013- H.R.3306, 113th Congress. This mode of service delivery, when implemented correctly, is noted to have equal outcomes to face-to-face interventions.

I ____hereby consent to engage in teletherapy with LBF Speech Communication Consulting Services, PLLC.

I understand that “teletherapy” includes treatment using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical information, both orally and visually. I understand the following with respect to teletherapy: I

Leasonna Boozer-Fuller, M. A., CCC-SLP-Agape Therapy Services “Communication Across the Lifespan.”

have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is confidential.

I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of LBF, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. Agape and LBF currently use Doxyme to provide teletherapy services. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. Teletherapy has been determined as an appropriate service delivery model for this patient. Teletherapy will only be used if determined to be at least as effective as in-person treatment. If teletherapy is not deemed as effective, you will be notified and referred back to in-person treatment. In order to participate in teletherapy, the patient must first participate in an in-person evaluation. For certain individuals, we ask that an adult facilitator be present in the room for assisting with technical difficulties, or keeping a child on task. Teletherapy may be used as the primary means of service delivery, or may be used in combination with in-person services.
I have read, understand and agree to the information provided above.

____

Patient Name (Printed)

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____ ________________

Patient / Guardian Signature Date