Sidney A. Gates, D. Min., M.S., LMFT
Licensed Marriage & Family Therapist
3633 Wheeler Road, Suite 100
Augusta, GA 30909
Phone: (706)364-0252 Fax: (706)364-0269

Today's Date: _____

PATIENT INFORMATION:

First Name:_____ Last:_____ MI. ___

Address: _____
Street City State Zip

Home Phone ( ) _____ Wk Phone: ( ) _____ Cell ( ) _____

Social Security No. :_____ Sex: M_____F_____

Date of Birth: _____Age: _____ Marital Status: S ___ M___D_____

Email:_____

Family Physician: (Name, Address, & Phone):_____

Place of Employment_____ Occupation: _____

Employer's Address:_____
Street City State Zip

Spouse's Name: _____ Date of Birth: _____

Spouse's Employer: _____ Occupation: _____

Social Security No. _____ Work Phone: _____

If Patient is a Minor:

Parent/Legal Guardian Name**:** _____

Social Security No.: _____ Date of Birth: _____

Address: _____
Street City State Zip

Place of Employment: _____ Work Phone: _____

Employer's Address: _____

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EMAIL AND TEXT MESSAGING CONSENT FORM

I, _____ authorize _____
(Patient printed name) (Therapist name)
to send automated appointment reminder email and/or text messages to me. I understand my Therapist is not responsible for any breach of privacy, confidentiality, or security of the emails/texts once they are received on my electronic devices. I understand the reminder system is automated and does accept reply emails/texts and is used for the sole purpose of appointment reminders. I agree to call the Clinicians Office at 706-364-0252 within regular business hours to cancel/reschedule appointments. I understand I may be charged a late cancellation/no show fee if I do not honor the 24-hour cancellation notice policy. In the case of an emergency, I agree to notify the office as soon as possible.

Contact by text messages:

- ☐ I **DO** wish to have this contact at the following phone number:

  _____

- ☐ I **DO NOT** wish to have this contact.

Contact by email:

- ☐ I **DO** wish to have this contact at the following email address:

  _____

- ☐ I **DO NOT** wish to have this contact.

_____ _____
(Patient/Custodial Parent/Legal Guardian) (Date of Signature)

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Insurance Information:

Primary Insurance Company: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Number:_____ Group:_____

Employer: _____SS#: _____

Relationship to Patient: _____

Secondary Insurance Company: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Number:_____ Group Number:_____

Employer:_____ SS#: _____

Relationship to Patient: _____

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment of private therapist fee benefits of insurance specified in attached form, and which may be otherwise payable to me, to be directly paid to Sidney A. Gates, D. Min., M.S., LMFT but not exceeding the balance due of such therapist's regular charges for such service. I permit a copy of this authorization to be used in place of the original document.

_____ _____

Signature of Patient/ Custodial Parent/Legal Guardian **Date**

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Consent for Disclosure of Information to Third Party Payers (Entities that pay your claims):

The undersigned authorizes Sidney A. Gates, D. Min., M.S., LMFT to release all patient information regarding diagnosis, treatment, and prognosis with respect to any physical, psychiatric, or drug/alcohol related condition for which the patient is being evaluated and treated, to the insurance company, the third party payer, or its representatives.

The undersigned acknowledges that such disclosures shall be limited to information that is reasonably necessary for the discharge of the legal or contractual obligations of the insurance company or third party payer.

The undersigned understands that the information obtained by use of this "Authorization" may be used by the above mentioned insurance company or third party payer to determine eligibility for benefits under an existing policy, and further understands that information obtained by such insurance company or third party payer shall not be released to any other person unless the undersigned so authorizes.

The undersigned acknowledges that he/she may request to receive a copy of this Authorization for disclosure of information to third party payers, and that he/she may revoke this Authorization at any time, except to the extent that action has been taken in reliance thereon.

The undersigned further acknowledges that this Authorization shall be valid during the pendency of these claims.

_____ _____

Signature of Patient/Custodial Parent/Legal Guardian Date

IMPORTANT INSURANCE INFORMATION

We do not guarantee insurance benefits or insurance payments. We also do not guarantee that a provider is in network for any patient's plan. We request all patients to contact their individual insurance company to verify benefits and provider network status before their appointment.

Please sign acknowledgement of this information.

_____ _____

Signature **Date**

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INFORMATION FOR COUPLES/MARRIAGE/FAMILY COUNSELING

IDENTIFIED PATIENT SAFEGUARDS

In accordance with the compliancy of the Health Insurance Portability and Accountability Act (HIPAA), this practice has placed certain safeguards to protect the health information of the identified patient.

The following safeguards apply to those receiving services for couples, marriage, or family counseling in this practice:

- There is only one identified patient 18 years of age or over (regardless of who is the policy holder, relationship to the patient, or who makes payments). Only the identified patient has the right to their protected health information.

- Only the identified patient can schedule, cancel, reschedule, or inquire about any appointments.

- Only the identified patient can have individual sessions. Individual sessions for any other party must have the approval of the identified patient and the therapist.

- The identified patient is ultimately responsible for all payments, regardless of the source of those payments. Billing issues must also be handled by the identified patient.

- The identified patient has the option to complete a release of information form, granting another party permission to schedule, cancel, reschedule, or inquire about appointments. This form is also required for the release of billing related questions.

By signing this form, you acknowledge that you have read, understand, and will abide by these safeguards.

_____ _____

Patient Date Spouse/Other Party Date

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PATIENT RIGHTS/RESPONSIBILITIES

PATIENT RIGHTS

Each patient, adult, child, adolescent, parent, or guardian has inherent and moral rights. It is my policy to ensure the rights of all patients by the following:

Courtesy: The patient deserves fair, considerate, humane, and respectful care. The patient will not be denied needed diagnostic and therapeutic services that are within my capabilities. Each patient will have equable and impartial care throughout this facility.

Confidentiality: Certain information obtained concerning you the patient, are, of course, confidential and privileged. When requested to furnish this classified information I will state that the information I have received is confidential and cannot be revealed except with authorization from the patient or someone empowered to speak for the patient. Medical information shall be available for use within my facility for direct patient care by all authorized personnel involved with the care of the patient.

The physical Medical Record is the property of my office and may not be removed from this jurisdiction and safekeeping except in accordance with a court order, subpoena, or other statute. The information contained in the Medical Record belongs to the patient. The patient is entitled to the right of protection of the confidentiality of this information but may authorize release of such confidential information through written consent. Upon employment, personnel involved with the care of the patient will sign a statement assuring the confidentiality of patient information.

Confidentiality in the counseling process is extremely important to me. In general, the privacy of our communications is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions:

1. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.
2. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, Georgia and South Carolina laws require me to file a report with the appropriate state agency.
3. If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek a medical professional's assistance with hospitalization for him/her or to contact family members or others who can help provide protection.
4. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The Consultant is also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together.

5. For clients under eighteen years of age, the law allows your parent/guardian access to information about your counseling with me. It is my practice to request your parent/guardian agree to receive only general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.
6. If your therapy is covered by insurance, they may request information about your condition and treatment. If your benefits are handled by a managed care company, they may require periodic information in order to authorize sessions. There is no confidentiality between myself and the insurance/managed care company. Once the information leaves my office, I am no longer responsible for the confidentiality of your records. If a collection agency must be used, they will receive only your name, address, and amount owed.
7. If a client files a worker's compensation claim, and I am providing treatment related to the claim, I must upon request, furnish copies of all medical reports and bills.
8. If a client files a complaint or lawsuit against me, I may disclose relevant information regarding that client in order to defend myself.

Knowledge: The patient has the right to know the identity of the staff members involved in their care.

The patient has the right to view their clinical records or reports. Office personnel will offer no explanation of such records or reports, but will encourage the patient or guardian to discuss them with me.

The patient will have access to their bill upon request by a manager or supervisor. The patient may request complete information and explanation of the charges for diagnostic and therapeutic services.

Complaints: The patient and their family have the right to make complaints regarding treatment. Presenting a complaint will not in itself affect the access to services now or in the future. The manager will review each complaint. Appropriate action will be taken and communication of that action provided to those involved.

PATIENT RESPONSIBILITIES

Information: The patient must provide true, accurate, and complete information.
Instructions: The patient must follow instructions for treatment. The patient should understand the consequences of not doing so, and if unable to comply, they must inform the staff or myself so that efforts can be made to help.
Refusal of Treatment: The patient and family are responsible for outcomes if they do not follow the medical plan of treatment and discontinue treatment against medical advice.

Respect and Consideration: Patients and their family must show consideration to other patients and staff, help control noise, distractions, and the "no smoking" policy of this building. Patients and family must respect the property of others and my office.

Obligations: The patient must keep appointments and fulfill obligations for their diagnostic and therapeutic services.

Behavior: The patient must abide by the rules and regulations of my office.

_____ _____

Signature of Patient/ Custodial Parent/Legal Guardian **Date**

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Not all services are a covered benefit in all insurance plans. **Patients are expected to pay for any part of charges not covered by insurance.** Unless prohibited by contract, patients will be billed for any unforeseen account balances after insurance has paid. A charge of $25.00 will be assessed on all returned personal checks. Should your account be turned over to a collection agency, you will be responsible for any collection fees, attorney fees, and court costs. The billing staff will discuss any questions with you at any time. If temporary financial problems affecting timely payment should arise, please contact us promptly for assistance in management of you account.

_____ _____
Signature of Patient/Custodial Parent/Legal Guardian Date

I agree there is to be no use of any type of visual or auditory recording devises at any time without the knowledge and consent of all adult parties present.

_____ _____
Signature of Patient/Custodial Parent/Legal Guardian Date

CANCELLATION/NO SHOW POLICY

You are expected to remember your appointments whether or not our office staff is able to contact you with a reminder call. Appointments must be canceled at least 24 hours prior to the scheduled appointment or you will be charged a 'no-show' fee of $65.00.

If an emergency prohibits you from the 24 hour notice, this should be the exception rather than the rule. You are asked to call the office during the available business hours rather than routinely using the after-hours protocol.

_____ _____
Signature of Patient/Custodial Parent/Legal Guardian Date

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Client Information and Informed Consent for Telemental Health Treatment

Telemental health services involve the use of electronic communications (telephone, video conference, etc.) to enable therapists to provide services to individuals remotely. Telemental health is a relatively recent approach to delivering care and there are some limitations compared with seeing a therapist in person. These limitations can be addressed and are usually minor depending on the needs of the client and the care with which the technology (cell phone, tablet, computer, etc.) is utilized.

Additional Points for Client Understanding:

- I understand that telemental health services are completely voluntary and that I can choose not to do it or not to answer questions at any time.
- I understand that none of the telemental health sessions will be recorded or photographed by my therapist without my written permission, and I understand that I may not record or photograph any of my telemental health sessions without the written permission of my therapist.
- I understand that the laws that protect privacy and the confidentiality of client information also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.
- I understand that because this is a technologically based method it may sometimes be necessary for a technician to assist with the equipment. Such technicians will keep any information confidential.
- I understand mental health is performed over a secure a communication system that is almost impossible for anyone else to access, but because there is still a possibility of a breach, I accept the very rare risk that this could affect confidentiality.
- I understand that there are risks from telemental health that may include but are not limited to the possibility despite all reasonable efforts by my provider: the transmission of medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or misunderstandings may occur more easily, particularly when care is delivered in an asynchronous manner.
- I understand that telemental health sessions will not be the same as an in-person session since I will not be in the same room as my therapist.
- I understand that I may experience benefits from the use of telemental health in my care, but that no results can be guaranteed or assured.
- I understand I am responsible for creating a safe, confidential space during sessions and I will engage in sessions in a private location where I cannot be heard or seen by others.
- I understand I am responsible for logging out or hanging up once sessions are complete.
- I understand you may contact me from a blocked number to avoid others knowing we have connected.
- I understand that if there is an emergency during a telemental health session, then my therapist will call emergency services and my emergency contact. I understand that if I do not follow safety/emergency protocols, my therapist has the right to discontinue use of teletherapy to protect my safety and well-being.
- I understand that if the video conferencing or telephone connection drops while I am in a session, I will provide a phone number (see below) for follow up contact if a plan for technical failures has not already been arranged with my therapist.
- I understand that I am required to provide an emergency contact (see below) in case of an emergency.
- I understand that telemental health-based services may not be appropriate for everyone seeking therapy. In person therapy may deemed necessary by my therapist.
- I understand I may be requested to install applications specific to treatment onto my phone, tablet, or computer device. Some applications specifically interact via phone /tablet, device, etc. and have the capability to report activity, GPS location, etc.
- I understand I have the right to withhold or withdraw this consent at any time. However, if I do so, this may require my therapist to provide referrals to other treatment providers if face-to-face services are not an option based on geography and/or circumstance.
- I understand the laws that protect the confidentiality of my personal health information also apply to telemental health, as do the limitations to that confidentiality discussed in the *Client Consent for Counseling* agreement. I also understand that the dissemination of any personally identifiable images or information from the telemental health interaction will not be shared without my written consent.

- I understand that email is not an appropriate means of communicating with my therapist in the case of emergency. I understand the email address provided below is to be used for providing this form only and is not an email that is monitored by my therapist. Any email address used by my therapist to engage in video conferencing is also not meant to be used in the case of an emergency or for counseling related content to be shared. I understand that email is not a secure communication medium for sensitive/personal information. I agree to call the office for scheduling, payments, insurance questions, or supplying other information.
- I understand that it is my responsibility to call and make payment for any balance due at the conclusion of my telehealth session.

Emergency Contact Name: _____ Emergency Contact Number: _____

CANCELLATION/NO SHOW POLICY

If you need to cancel an appointment, please follow the same procedure you already agreed to in the *Client Consent for Counseling* documents. **As a reminder, cancellations should be made within 24 hours of your scheduled session time, unless you have a same day emergency arise.** Please call and inform our office of any same day emergencies. **If cancellation is not made within 24 hours, I reserve the right to charge a $65 fee in the same way a fee is charged for missing or late cancelling in-person sessions.**

PAYMENT FOR SERVICES

As with your in-person sessions, we will submit a claim to any insurance provider you gave us written consent to bill in your *Consent for Disclosure of Information to Third Party Payors*. Not all mental health services are a covered benefit in all insurance plans. If you are unsure of coverage, please contact your insurance company. **Patients are expected to pay for any part of charges not covered by insurance per usual procedure (i.e., copay, deductibles, etc.)**. Billing processes are the same for telemental health services as with in office visits, as outlined in the *Client Consent for Counseling* document. Self-pay arrangements already in place will remain the same for teletherapy sessions. **Please call the office to make a payment by at the conclusion of your session.**

CONSENT

I consent to engaging in telemental health as part of my treatment with Sidney Gates, LMFT. I understand that "telemental health" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of personal health information, and education using interactive audio, video, or data communications. I understand the information provided above regarding telemental health. I hereby give my informed consent for the use of telemental health in my care.

Name of Patient (Print) _____ Email (Print) _____ Cell Phone _____

Signature of Patient _____ Date _____

Name of Legal Guardian [if patient under 18] (Print) _____ Signature of Legal Guardian _____ Date _____

INFORMED CONSENT FOR IN-PERSON SERVICES AND COVID

Decision to Meet Face-to-Face

There may be a need to meet in person for some or all sessions. If there is a resurgence of COVID or if other health concerns arise, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for both of our well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, if it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies.

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

Your Responsibility to Minimize Your Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, our staff, our families, and other patients) safer from exposure, sickness, and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each point below to indicate that you understand and agree to these actions:

- Face masks are currently optional. You may wear a mask in the office if you choose. _____
- The waiting room should be limited to patients being seen for therapy sessions. Minor patients or patients needing physical assistance may bring 1 person with them into the waiting room. Please contact the office if this creates a problem for you. _____
- You will take steps between appointments to minimize your exposure to COVID. _____
- If you have a job that exposes you to other people who are infected, you will immediately inform me/office staff. _____
- If you or a resident of your home tests positive for the infection or have been symptomatic from COVID within the last 10 days, you will immediately let me/office staff know and we will then [begin] resume treatment via telehealth. _____
- I understand that my therapist cannot be held responsible for any exposure risks outside of the therapy office in other parts of the building or the parking lot. _____

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

If You or I Are Sick
You understand that I am committed to keeping you, me, my staff, and our families safe from the spread of this virus. If you show up for an appointment and I, or my office staff, believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I, or my staff, test positive for the coronavirus and may have exposed you, I will notify you so that you can take appropriate precautions.

Informed Consent
This agreement supplements the general informed consent/business agreement.

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

_____ _____
Patient Date

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INFORMED CONSENT AND TREATMENT AUTHORIZATION:

By signing this Patient Informed Consent and Authorization as the Patient or Guardian of said Patient, I acknowledge that I have read, understand, and agree to the terms and conditions contained in this form. I am voluntarily agreeing to receive mental health assessment, treatment and services, from Sid Gates, D. Min., M.S., LMFT, for me (or my child if said child is the patient).

I understand that I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my/their health insurance. Deductibles and co-payments will be made at the time services are rendered.

_____ _____
Signature Date

IN CASE OF EMERGENCY CONTACT:

NAME:_____RELATIONSHIP:_____

ADDRESS:_____PHONE NO:_____

Whom may we thank for referring you to us?

_____

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****WOULD YOU LIKE INFORMATION RELEASED TO YOUR PRIMARY CARE PHYSICIAN?**

YES_____ (COMPLETE ALL INFORMATION BELOW – SIGN & DATE)

NO_____ (PLEASE SIGN & DATE AT THE BOTTOM)**

Client:_____ Birthdate:_____

I, _____, authorize Sidney A. Gates, LMFT and my

primary care physician,

Dr. _____

Phone#_____fax#_____

Address_____

_____

to exchange information regarding my mental health and/or substance abuse treatment and medical health care for coordination of care purposes as may be necessary for the administration and provision of my health care coverage. The information exchanged may include information on mental health care and/or substance abuse care and/or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for 12 months from the date of my signature below or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral health provider. I also understand that it is my responsibility to notify my behavioral health provider if I choose to change my primary care physician.

_____ _____

Signature of Patient/ Custodial Parent/Legal Guardian **Date**