

A HEALING ALTERNATIVE COUNELING AND WELLNESS CENTER, LLC

8603 CROWNHILLE SUITE 29 SAN ANTONIO, TX 78233

PHONE: (210)705-2121

FAX: (210) 568-4816

INFO@FAITHGHARPER.COM

Hey there, new person!

Enclosed in this packet is all the basic forms you will need to complete before your first distance counseling. Paperwork can be either emailed or faxed to my office prior to your scheduled appointment.

In addition to the information I collect from in-office clients, I also require the following information from clients receiving distance counseling. They include a crisis-safety plan with local information in case of an emergency, a consent to release information for me to contact at least one professional care provider in your area in case of an emergency (if you are not receiving services from anyone else, it can be your local community mental health clinic), and a specific informed consent regarding distance counseling. You will notice within this informed consent that I am reiterate that you must be either be a resident of Texas or residing out of the United States for me to provide you counseling services

Copies of my HIPPA policy and my Social Media Policy are available as separate downloads and should be read before completing this packet. Additionally, I keep printed copies of them in the office and can provide them to you at your request.

Please have each person who is entering services complete a packet. (Though don't freak out by the counseling contract...if you are attending as a couple or family unit you will only pay for the service visit, not per person!)

If you have any questions, do not hesitate to contact me at info@faithgharper.com

Faith G. Harper

Faith G. Harper, PhD, LPC-S, ACS, ACN
A Healing Alternative Counseling and Wellness Center, LLC
info@faithgharper.com www.faithgharper.com
Phone: (210)705-2121 Fax: (210) 568-4816

Counseling Contract

Counseling is most helpful when it takes place in a framework of trust, clarity, and understanding. This contract is intended to clarify and help this relationship. Should you have any questions concerning this covenant, please discuss them with me.

Financial Understanding

I/we understand that the fee for a 50 minute session is **\$135.00**; this fee is the same for an initial visit.

I have discussed this amount with the therapist along with my ability to pay. **I agree to a fee in the amount of _____.**

If I choose to use my insurance benefits to offset the cost of my therapy, then I understand that the full fee will be charged.

I agree to be responsible for that full fee amount.

Cancellation Policy

I understand that I will be charged the full fee of **\$135.00 for a missed appointment or if I fail to cancel without 24 hours notification.** This can be discussed with your therapist if special circumstances result in a missed appointment.

Limits of Confidentiality

I understand that while confidentiality is central to the process of therapy, it must be broken and a report made to the proper authorities when there is abuse or neglect of children, disabled persons, and the elderly; when there is intent to harm oneself, another, or property; or when a court order is issued.

Terminating Therapy

I understand that though I may stop therapy at any time, the ending of therapy is best if discussed with my therapist at least one session before it ends.

Consent to Counseling

I understand that there are certain risks in therapy and that there may be alternatives to therapy. I agree to counseling with Faith G. Harper. These services may also include group therapy, psychoeducation, assessment and diagnostic impressions, and referrals for other needed services.

Signed _____

Printed Name _____

Date _____

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CONTACT INFORMATION

Today's Date _____ Reverified Date _____ Reverified Date _____

Legal Name _____
Last First MI

Preferred Name _____

DOB ____/____/____

Legally Authorized Representative (if applicable) _____
Last First MI

Local Address _____
Street Apt#

City, State, Zip

Preferred Form of Contact? ___ Phone ___ Cell Phone ___ Text ___ Email

Cell Phone _____
If Phone Contact checked, OK to leave message? _____

Home Phone _____
If Phone Contact checked, OK to leave message? _____

Email address: _____

If you marked that you prefer email contact or text contact, please note the following:

I understand that the confidentiality of information transmitted via email or text cannot be guaranteed.

_____ *Your Initials*

In Case of Emergency, Notify:

Name _____
First Last

Relationship _____

Contact info: _____
Street Apt#

City, State, Zip

Home Phone _____

Cell Phone _____

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Signed _____
Witness _____
Date _____

Signed _____
Witness _____
Date _____

Receipt of Notice of Privacy Practices Form
A Healing Alternative Counseling and Wellness Center, LLC
Faith G. Harper, PhD, LPC-S

I, _____, hereby acknowledge receipt of the NOTICE OF PRIVACY PRACTICES from my therapist.

The NOTICE OF PRIVACY PRACTICE provides detailed information about how the practice may use and disclose my confidential information.

I understand that my therapist has reserved a right to change his or her privacy practices that are described in the NOTICE.

I also understand that a copy of any Revised NOTICE will be provided to me or made available.

CLIENT SIGNATURE

DATE

Faith G. Harper, PhD, LPC-S
A Healing Alternative Counseling and Wellness Center, LLC
info@faithgharper.com www.faithgharper.com
Phone: (210)705-2121 Fax: (210) 568-4816

Social Media Acknowledgement Form

I acknowledge that I have been provided a copy of Faith Harper's social media policy which remains in effect even when I am no longer receiving services from her.

I understand that this policy is available for download and review at any time from her website (www.faithgharper.com) and updates in this policy will be discussed with me, if I am currently receiving services from her.

I understand that if any questions about social media arise are best discussed directly with her during our sessions.

Client Name: _____

Client Signature: _____

Date: _____

Counselor Signature: _____

Date: _____

Life History Questionnaire

FAITH G. HARPER, PhD, LPC-S, ACS, ACN

The purpose of this questionnaire is to obtain some information regarding the issues that bring you in today, as well as some of your experiences and background. Completing these questions as fully and as accurately as possible will benefit you through the development of a treatment plan suited to your specific needs.

Name: _____ Date: _____

Address: _____

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

Email Address: _____

DOB: / / Age: Occupation: _____

SIGNIFICANT RELATIONSHIP STATUS:

Single Engaged Married Separated Divorced Widowed Committed Relationship

LIST ANY MEDICATIONS YOU ARE TAKING:

<u>Name</u>	<u>Dosage</u>	<u>Prescribed for</u>
_____	_____	_____
_____	_____	_____

PLEASE STATE WHAT BRINGS YOU IN:

HOW LONG HAS THIS BEEN OCCURRING?

On the scale below, please circle the severity:

1 2 3 4 5 6 7 8 9 10
 mildly upsetting ← — — — — — — — — — → incapacitating

ALCOHOL AND OTHER DRUG USE

Please tell me about your use of alcohol and other substances:	Never	Seldom	Once a month	2-3 times a month	Weekly	Daily
I drink 4 or more drinks in a 24-hr period.	<input type="checkbox"/>					
I have missed work/school due to drinking.	<input type="checkbox"/>					
After drinking, I have forgotten where I was or what I did.	<input type="checkbox"/>					
I use other recreational drugs*.	<input type="checkbox"/>					
I have missed work/school due to recreational drugs*.	<input type="checkbox"/>					
After using recreational drugs*, I have forgotten where I was or what I did.	<input type="checkbox"/>					

***RECREATIONAL DRUGS INCLUDE**, among others: marijuana; cocaine; ecstasy; heroin; meth; as well as any prescription or over-the-counter drugs taken for recreational purposes.

PREVIOUS MENTAL HEALTH TREATMENT:

Please list any psychiatrists, therapists, hospitals, self-help groups, and residential treatment centers, and the issues for which you were seen.

FAMILY MENTAL HEALTH HISTORY

Clinical Diagnosis	NO ONE	If YES, please check the box for <u>all</u> applicable family members							Successfully Treated?	
		Mother	Father	Brothers	Sisters	Cousins	Aunts/Uncles	Grand-parents	Yes	No
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety/Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD (Attention Deficit)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-traumatic Stress Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive-Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Borderline Personality Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia or Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or Other Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other family mental health information: _____

Please describe any illness, loss, accident, or hospitalization that had a big impact on your life, and give the dates of their occurrences

Do you have any major health concerns?

CURRENT & PREVIOUS SYMPTOMS/BEHAVIORS/EXPERIENCES

NOW	PAST		NOW	PAST	
DISTRESSING SYMPTOMS			WORK/ACADEMIC CONCERNS		
<input type="checkbox"/>	<input type="checkbox"/>	Stress	<input type="checkbox"/>	<input type="checkbox"/>	Procrastination
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Time management
<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	Poor performance evaluations/grades
<input type="checkbox"/>	<input type="checkbox"/>	Perfectionism	<input type="checkbox"/>	<input type="checkbox"/>	Test, speech, or performance anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Fearfulness/paranoia	<input type="checkbox"/>	<input type="checkbox"/>	Conflict with a colleague, boss, or professor/teacher
<input type="checkbox"/>	<input type="checkbox"/>	Obsessive thoughts	BODY IMAGE AND FOOD USE		
<input type="checkbox"/>	<input type="checkbox"/>	Compulsions/rituals	<input type="checkbox"/>	<input type="checkbox"/>	Binge eating
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Purging (vomiting)
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	Laxative use/abuse
<input type="checkbox"/>	<input type="checkbox"/>	Motivation problems	<input type="checkbox"/>	<input type="checkbox"/>	Diet pill use/abuse
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty <i>falling</i> asleep	<input type="checkbox"/>	<input type="checkbox"/>	Restricting food intake or avoiding food/fasting
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty <i>staying</i> asleep	<input type="checkbox"/>	<input type="checkbox"/>	Overeating
<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	Dieting
<input type="checkbox"/>	<input type="checkbox"/>	Excessive crying	<input type="checkbox"/>	<input type="checkbox"/>	Being overweight or underweight
<input type="checkbox"/>	<input type="checkbox"/>	Irritability/anger/hostility	<input type="checkbox"/>	<input type="checkbox"/>	Excessive exercise
<input type="checkbox"/>	<input type="checkbox"/>	Mania (overly energized with unusual thoughts or behaviors)	ADDICTION/DEPENDENCE CONCERNS		
<input type="checkbox"/>	<input type="checkbox"/>	Suicidal feelings/thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol addiction/dependence/overuse/abuse
<input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt(s)	<input type="checkbox"/>	<input type="checkbox"/>	Drug addiction/dependence/overuse/abuse
ROMANTIC RELATIONSHIP CONCERNS			<input type="checkbox"/>	<input type="checkbox"/>	Prescription drug addiction/dependence/overuse/abuse
<input type="checkbox"/>	<input type="checkbox"/>	Dating concerns	<input type="checkbox"/>	<input type="checkbox"/>	Smoking/tobacco use
<input type="checkbox"/>	<input type="checkbox"/>	Concerns about sex	<input type="checkbox"/>	<input type="checkbox"/>	Gambling
<input type="checkbox"/>	<input type="checkbox"/>	Conflict with partner/spouse	<input type="checkbox"/>	<input type="checkbox"/>	Excessive internet use
<input type="checkbox"/>	<input type="checkbox"/>	Break-up/end of romantic relationship	<input type="checkbox"/>	<input type="checkbox"/>	Sexual addiction
SOCIAL RELATIONSHIP CONCERNS			CONCERNS INVOLVING VIOLENCE		
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty making friends	<input type="checkbox"/>	<input type="checkbox"/>	Unwanted sex
<input type="checkbox"/>	<input type="checkbox"/>	Loneliness	<input type="checkbox"/>	<input type="checkbox"/>	Being stalked
<input type="checkbox"/>	<input type="checkbox"/>	Social anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Intimate relationship violence
<input type="checkbox"/>	<input type="checkbox"/>	Conflict with friend(s)	<input type="checkbox"/>	<input type="checkbox"/>	Problems with anger control
GENDER/SEXUAL ORIENTATION CONCERNS			<input type="checkbox"/>	<input type="checkbox"/>	Participant in a violent incident
<input type="checkbox"/>	<input type="checkbox"/>	Gender identity or gender issues or questions	<input type="checkbox"/>	<input type="checkbox"/>	Witness of a violent incident
<input type="checkbox"/>	<input type="checkbox"/>	Lesbian/gay/bisexual issues or orientation questions	<input type="checkbox"/>	<input type="checkbox"/>	Perpetrator of abuse (physical/sexual/psychological)
<input type="checkbox"/>	<input type="checkbox"/>	Asexual/Demisexual/Greysexual issues or questions	<input type="checkbox"/>	<input type="checkbox"/>	Survivor of abuse (physical/sexual/psychological)

HOME AND FAMILY EXPERIENCES

Did the following occur in your family/home environment?	Yes	No	Not Sure
---	------------	-----------	-----------------

Parents divorced or permanently separated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent, hostile arguing among family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Death of a parent or sibling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parent(s) or sibling(s) with a drinking or drug problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family member with an eating problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family member with a debilitating illness, injury, or disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family member prosecuted for criminal activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family member attempted/committed suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical abuse in your family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual abuse in your family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is there any other information about your mental health/emotional wellness that you believe will be pertinent to or could impact your care and treatment? Please explain below.

I hereby certify that all the above information is true and correct to the best of my knowledge and belief.

Signature

Name

Date

My Personal Crisis Response Safety Plan

Should I experience a mental health crisis, I will do the following:

1. I will try to identify specifically what is upsetting me.
2. I will write down other responses I can have to this situation that do not involve harming myself.
3. I will review the thoughts and conclusions that I've come to about this situation and try to figure out if they are either accurate or helpful.
4. I will do something I enjoy that helps me feel better for at least 30 minutes. Some of these activities may include:

5. I will talk with someone whom I trust to be supportive about how I'm feeling. These people may include (list names and numbers):

6. I repeat all of the above *at least one more time*.
7. If the thoughts continue, and I find myself preparing to do something to myself, I will call my preferred local crisis line or suicide hotline (example: 1-800-273-TALK). Please list options below:

8. If I still feel in danger of harming or killing myself and don't feel I can control my behavior I will call 911 or go to the ER. My preferred ER is:

Name and Phone Numbers of Other Important Contacts for Me

Case Manager: _____
Therapist: _____
Psychiatrist: _____
Clinic Where I Get Services: _____
PCP: _____
Emergency Contact: _____

Name

Signature

Date

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I _____ authorize Faith G. Harper to:

- _____ release to:
- _____ obtain from:
- _____ exchange with:

The following information pertaining to myself:

- _____ treatment summary
- _____ history/intake
- _____ diagnosis
- _____ psychological test results
- _____ psychiatric evaluation/medication history
- _____ dates of treatment attendance
- _____ other (specify) _____

For the purpose of:

- _____ evaluation/assessment and/or coordinating treatment efforts
- _____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

Signature of Client
or Legally Authorized Representative

Date

Informed Consent for Technology-Assisted Counseling

Signing this form is your agreement for psychotherapy services conducted by
Faith G. Harper, PhD, LPC-S, ACS, ACN

The purpose of this Informed Consent for Technology Assisted Counseling is to inform you, the client, about the process of online counseling services, the counselor and the potential risks and benefits of these services. The purpose is to also help safeguard you, the client, and give you information regarding alternatives to online services. This consent is an addendum to the face-to-face informed consent you, the client, are required to sign.

Please read the entire document. Please print the document, place a check mark stating you have read the document, sign, and then mail to the address located at the bottom of the page.

The Technology-Assisted Counseling Process

Privacy and Confidentiality

Maintaining client confidentiality is extremely important. The counselor will take extraordinary care and consideration to prevent unnecessary disclosure. Information about the client will only be released with his or her permission except obligated to do during a crisis situation or otherwise obligated to do so by law.

Although the internet provides the appearance of anonymity and privacy in counseling, privacy is more of an issue online than in person. The client is responsible for understanding the potential risks of confidentiality being breached through unencrypted email, lack of password protection or leaving information on a public access computer in a library or internet café.

Other potential risks of breaching confidentiality could include messages failing to be received if they are sent to the wrong address or if they are just not noticed by the counselor. Confidentiality could be breached in transit by hackers or internet service providers or at either end by others with access to the client's account or computer. Clients accessing the internet from public locations such as a library, computer lab, or café should consider the visibility of their screen to people around them. Position yourself to avoid others seeing your screen. Using cell phones can be risky in that signals are scrambled but rarely encrypted.

The counselor has a right to his or her privacy and may restrict the use of any copies or recordings the client makes of their communications. Clients must seek the permission of the counselor before recording any portion of the session and/or posting any portion of said sessions on internet websites such as Facebook or YouTube.

The client is responsible for securing their own computer hardware, internet access points, chat software, email and passwords that are encrypted, secure, and Hippa compliant when possible. If encryption is not made available to client, client should be aware that they are risking unauthorized monitoring of transmissions and/or records of Internet counseling sessions.

You agree to work with me online using Doxy.Me, or another encrypted video and/or chat service determined to be suitable by me or by phone call (for voice chat only). I understand that my therapist will provide me a link to the host site for our session.

Additionally,

- Text messaging via mobile phone is acceptable for appointments and housekeeping issues only.
- I do not store your name in my phone.
- If you call me, please be aware that unless we are both on land line phones, the conversation is not confidential.
- I will not respond to personal and clinical concerns via regular email.
- If you wish to use email as a way to "journal" information between sessions, you understand that I may not have the opportunity to review your journal emails until our next scheduled session.

I make every effort to keep all information confidential. Likewise, if we are working online together, I ask that you determine who has access to your computer and electronic information from your location. This would include family members, co-workers, supervisors and friends and whether or not confidentiality from your work or personal computer may be compromised due to such programs as a keylogger.

I encourage you to only communicate through a computer that you know is safe i.e. wherein confidentiality can be ensured. Be sure to fully exit all online counseling sessions and emails. If you used location-based services on your mobile phone, you may wish to be aware of the privacy issues related to using these services. I do not place my practice as a check-in location on various sites such as Foursquare. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at my office on a weekly basis.

Please be aware of this risk if you are intentionally "checking in," from my office or if you have a passive LBS app enabled on your phone.

I may need to consult with other professionals regarding my clients, however, the client's name or other identifying information is never disclosed. The client's identity remains completely anonymous, and confidentiality is fully maintained.

It is not a regular part of my practice to search for client information online through search engines such as Google or social media sites such as Facebook. Extremely rare exceptions may be made during times of crisis. If I have a reason to suspect that you are in danger and you have not been in touch with me via our usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if I ever resort to such means, I will fully document it and discuss it with you when we next meet.

Lack of Non-Verbal Cues and Asynchronous Communication

The client should be aware that misunderstandings are possible with telephone, text-based modalities such as email, and real-time internet chat, since non-verbal cues are relatively lacking. Even with video chat software, misunderstandings may occur since bandwidth is always limited and images lack detail. Counselors are observers of human behavior and gather much information from body language, vocal inflection, eye contact and other non-verbal cues. If you have never engaged in online counseling before, have patience with the process and clarify information if you think your counselor has not

understood you well. Be patient if your counselor asks periodically for clarification as well.

Since asynchronous communication is “not in real time,” turnaround time for responding to emails will “lag” a response. Be aware of different time zones as well. The counselor will make every effort to respond to email requests within a 12-24 hour period. Work with your counselor to identify local resources if you have concerns about the timeliness of responses.

Benefits of Receiving Technology-Assisted Counseling

Potential benefits of receiving mental health services online include both the circumstances in which the counselor considers online mental health services appropriate and the possible advantages of providing those services online. For example, the potential benefits of email may include 1) being able to send and receive messages at any time of the day or night; 2) never having to leave messages with intermediaries, avoiding voice mail and “telephone tag”; 3) being able to take as long as one wants to compose and having the opportunity to reflect upon one’s messages; 4) automatically having a record of communications to refer to later; and 5) feeling less inhibited than in person.

Text-based chat has many of the same advantages of convenience, feeling reduced scrutiny from the counselor having time to compose a response and being able to refer back to chat logs for reference. Video chat is also convenient, allowing clients to potentially be counseled from anywhere once one gains an internet signal and can operate the necessary hardware.

Potential Risks of Receiving Technology-Assisted Counseling & Safeguards

There are various risks related to providing technology-assisted counseling services related to the technology used, the distance between counselor and client, and issues related to timeliness. These risks of concerns for privacy and confidentiality were mentioned in section A. above. Your counselor has selected a video- conferencing account that is encrypted with a HIPPA compliant secure platform to allow for the highest possible security and confidentiality of the content of your sessions. Your personal information is encrypted and stored on a secure server.

The client is responsible for creating and using additional safeguards when the computer used to access services may be accessed by others such as creating passwords to use the computer, keeping their Email and chat IDs and passwords secret, and maintaining security of their wireless internet access points (where applicable.) Please discuss any such concerns with your counselor during your first session so as to develop ways to limit risks. If there is ever a disruption or disconnection of services on the internet, the client will need to call Dr. Harper directly (210-705-2121) if phone service is available.

Dual Relationships & Social Media

Dual relationships can impair the therapeutic process, your therapist's objectivity, clinical judgment, or therapeutic effectiveness that could be exploitative in nature. I will never acknowledge working therapeutically with anyone without his/her written permission. In

some instances, even with permission, I will preserve the integrity of our working relationship. For this reason, my social media policy is the same for distance counseling clients as it is for in-office clients.

Alternatives to Technology-Assisted Counseling, Termination & Referrals

Online counseling may not be appropriate for many types of clients including those who have numerous concerns over the risks of internet counseling, clients with active suicidal/homicidal thoughts, clients who are experiencing active manic/psychotic symptoms, or clients who are minors. An alternative to receiving mental health services online would be receiving mental health services face to face with the counselor or adjunct using both modalities or working with another counselor. The online counselor can and will assist clients who would like to explore face-to-face options in their local area. Many state and local agencies will treat low-income clients on a sliding scale fee.

Also, I do not accept clients who, in my opinion, I cannot help. In such a case, I will give you a number of referrals that you may contact. If at any point during psychotherapy I assess that I am not effective in helping you reach your therapeutic goals, I am obliged to discuss this with you up to and including termination of treatment. In such a case, I would give you a number of referrals that may be of help to you. You have the right to terminate therapy at any time. Please feel free to request a referral any time you think a different counseling relationship would be more practical or beneficial for you. If you choose to do so, I will offer to provide you with names of other qualified professionals whose services you might prefer.

Proxies

The counselor only provides treatment via technology to clients who are legally able to consent for themselves to receive mental health services. Clients who are not in such positions include children under the age of consent (age 18 in most cases) or clients who have a legally appointed guardian.

Telephone & Emergency Procedures

If you need to speak with me between sessions to alert me of an emergency, please call my office at 210-705-2121. Your call will be returned as soon as possible. Messages are checked daily (but never during the night time.) Messages are checked less frequently on weekends and holidays.

If the client is in a state of crisis or emergency, the counselor recommends the client dial 911 or go to the local emergency room. Clients 1- 800-SUICIDE or 1-800-273-TALK. Deaf clients can call 1-800-799-4TTY.

All distance clients will be required to complete a Crisis Safety Plan before beginning therapeutic services as well as a consent to release information for any of your local treatment providers (or your local community mental health agency should you not be in services locally). If I suspect you are in crisis either during our sessions or between sessions, I will contact this treatment provider or agency to ensure you receive support. If I am unable to do so, I will contact local law enforcement and request a welfare check on your behalf.

Records

The counselor will maintain records of online counseling services. These records can include reference notes, copies of transcripts of chat and internet communications, and session summaries. These records are confidential and will be maintained as required by applicable legal and ethical standards according to the American Counseling Association and the Texas Administrative Code. The client will be asked in advance for permission before recording any audio or video session.

J. Fee for Service and Cancellation Policy

All payments will be processed through Paypal.com. My practice is “fee for service” and that means that fees are due at the time of your appointment.

Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24-hour notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. If we are scheduled for an online synchronous chat, audio or video conference and we are unable to connect or are disconnected during a session due to a technological breakdown, please try to reconnect within 10 minutes. If reconnection is not possible, contact me to schedule a new session time.

{ } Yes, I have read and agree to the terms listed above in the Informed Consent. I understand that Faith Harper is a Licensed Professional Counselor who follows the laws and professional regulations of the State of Texas. I understand the psychotherapy treatment will be considered to take place in the state of Texas. I understand that telephone/online psychotherapy is not a substitute for medication under the care of a psychiatrist or doctor. I understand that online and telephone therapy is not appropriate if I am experiencing a crisis or having suicidal or homicidal thoughts. In case of emergency situations, I will contact the resources listed in section H above.

I understand my signature is an agreement for psychotherapy services conducted by Faith G. Harper, PhD, LPC-S, ACS, ACN.

Client Printed Name

Client Signature

Date

