PATIENT NAME (Legal)			PARENT NAME (IF PATIENT IS UNDER AGE 18)		
Preferred Name (optional)			Relationship to Patient		
Date of Birth	Age	Gender	Address (if different)		
Address			City	State	Zip Code
City	State	Zip Code	Parent Email		
Cell Phone #	Cell Carrier		Parent Cell #	Parent Cell Carrier	
Patient Email			Special Communication Requests		

Emergency Contact Name	Who referred you to HPA/LiveWell?
Emergency Contact #	Reason for appointment/referral
Emergency Contact Relationship	

INSURANCE INFORMATION

Primary Insurance Company		Policy # or ID #	Group #
Person Providing Insurance	Date of Birth - Person Providing Insurance	Relationship to Patient	
Secondary Insurance Company		Policy # or ID #	Group #

I authorize HPA/LiveWell to release any information acquired during treatment to my insurance carrier. This authorization shall remain valid until written notice is given revoking the authorization. I understand that I am financially responsible for all charges whether they are covered by insurance. This signature will authorize consent to treat the above-named patient.

PATIENT NAME:		DATE:	
PATIENT SIGNATURE:			
PARENT/GUARDIAN SIGNATURE: (if patient is under 18)			

CONSENT FOR PSYCHOTHERAPY VIA TELEHEALTH

I _____ hereby consent to participate in psychotherapy via telehealth with HPA/LiveWell.

I understand that "telehealth" is the practice of delivering clinical mental and behavioral healthcare services via tech-assisted media or other electronic means between a NYS licensed clinician and a patient who are located in two different locations. I understand that telehealth means using electronic information and communication methods to connect with providers to deliver assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient. I understand that by participating in telehealth, I will be sharing personal data, email messages, telephone conversations and interactive video and data communications with HPA/LiveWell.

PATIENT RIGHTS & RESPONSIBILITIES

1. I have the right to withdraw this consent at any time, without affecting my right to future care or treatment.
2. I acknowledge there are risks, benefits, and consequences associated with telehealth, including, but not limited to the transmission of personal information could be disrupted or distorted by technical failure, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I accept that HPA/LiveWell has implemented safety measures to ensure each telehealth session is secure and no part of an encounter will be recorded.
4. I understand telehealth sessions must maintain applicable privacy and security requirements, including but not limited to compliance with HIPAA. This means under no circumstance may anyone record any visual or auditory parts of telehealth sessions. **Breach of confidentiality relating to PHI (protected health information) violates NYS and Federal law.**
5. I understand that, although rare, tech problems may delay or interrupt a telehealth session. If a session is interrupted due to technology, all parties will attempt to log back in as soon as possible. If unable to connect within ten minutes, contact the HPA Admin Team via ***frontdesk@albanyhpa.com*** or **518.218.1188** to reschedule.

EMERGENCY PROTOCOLS

6. I accept that telehealth does not provide emergency services. If at any time I am at risk to harm myself or others, I agree that I will call 911 or proceed to the nearest hospital emergency room for immediate help.
7. I acknowledge emergency/crisis support resources are available from the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) or Albany County Mobile Crisis at 518.549.6500.
8. I agree to inform my clinician if I am participating in session from a physical location different from my address on file.
9. I accept that HPA/LiveWell requires an emergency contact person be identified for each patient to reach on your behalf in a life-threatening emergency. The emergency contact person will only be contacted to go to your location or take you to the hospital to help to keep you safe.

If I have any concerns related to my care, I am able and willing to contact either Dr. Julie Morison, HPA's Owner/Director, or Marianne Reid Schrom, Practice Administrator via email at ***frontdesk@albanyhpa.com***.

By signing below, I have read and understand the information above, and all my questions have been answered to my satisfaction.

PATIENT NAME:		DATE:	
PATIENT SIGNATURE:			
PARENT/GUARDIAN NAME:		PARENT/GUARDIAN PH #:	
PARENT/GUARDIAN SIGNATURE:			
EMERGENCY CONTACT:		EMER. CONTACT PH #:	

INFORMED CONSENT FOR OUTPATIENT SERVICES

Welcome to HPA/LiveWell! This document contains information regarding the services provided by our clinical staff. Please read carefully and ask for clarification where needed. By signing this form, you acknowledge that you have read these policies and consent to participate in the treatment provided by HPA/LiveWell.

SERVICES PROVIDED

HPA/LiveWell provides a spectrum of psychological services including, but not limited to, individual and family counseling, ADHD testing and group therapy. Our intensive outpatient program (IOP) focuses on the treatment of eating disorders which includes nutritional counseling, group psychotherapy and medical follow-up for IOP compliance, as needed. We also offer outpatient services for psychological assessments as well as individual, family and group psychotherapy. Our clinical staff consists of doctoral degreed psychologists and doctoral trainees, a nurse practitioner, licensed dietitian, social workers and mental health counselors. HPA/LiveWell is a teaching practice that may have students present during select group and individual sessions. Please inform our administrative team if you wish to discuss the presence of students with our clinical staff.

Services vary depending on the personalities, orientation and education of therapists and patient, your goals for change and the areas you wish to address. Psychotherapy calls for a very active effort on your part and the most successful patients are those who utilize what they learn in treatment within their daily lives.

At times it can be helpful to have family members or a significant other participate in your care. If you feel this would be helpful, please work with your therapist to connect with these individuals.

Additionally, with your permission, and when appropriate, our clinicians would like to coordinate care with your other providers. Please make sure to notify your therapist of outside providers and complete the required Release of Information form(s) (ROI).

Please be advised that psychotherapy can have benefits and risks. Oftentimes, the information discussed may involve unpleasant aspects of your life and you may experience uncomfortable feelings. Changes made within your life can have a disruptive effect on your family and other interpersonal relationships, however psychotherapy has also been proven to have benefits to the lives of the people who go through it. Therapy often leads to solutions to specific problems, establishing healthy coping skills, improved relationships, and significant reductions in feelings of distress. There are no guarantees of what you will experience. Our intention is to provide a therapeutic environment which allows you to make the changes you seek.

CONFIDENTIALITY
Our minimum practice standards meet the standards of the Health Care Portability and Accounts Act (HIPAA).

COMMUNICATION WITH CLINICAL STAFF
The clinical staff are often with patients and, most times, not immediately available by phone. Along with our administrative team, HPA/LiveWell has confidential voicemail system that is regularly monitored, and calls are addressed in a timely manner. If your therapist is out of the office for an extended period of time, coverage will be prearranged and communicated to you. **Please be advised that we do *not* provide emergency or crisis care**. We advise you to contact your family practitioner, dial 911 or seek the nearest emergency center in the event of a life-threatening situation.

We are unable to ensure the confidentiality of any form of communication through electronic media and strongly advise you avoid these forms of communications. Should you wish to communicate with your clinician via email you must sign a release of electronic information form stating that you understand the risks associated with this form of communication. Contact our administrative team for more details. Communication with existing patients through the website is prohibited.

M**INORS**
HPA/LiveWell welcomes adolescent patients, however parental/ guardian consent to treatment is required. While parents/guardians have the legal right to all treatment information, it is our policy to ask parents/ guardians to respect the confidentiality of adolescents age 13 and over. Clinicians will provide parents/ guardians with general information about progress, either by phone or through family sessions, upon request. If a clinician believes there is imminent risk that an adolescent will seriously harm self or others, the clinician will disclose the information in accordance with ethical and legal obligations. Behavior that may negatively affect an adolescent patient's health or well-being will also be addressed with the patient's knowledge.

It is the responsibility of the parent/ guardian to inform the office of any custodial changes or of any limitations to the supports with whom contact is to be made.

APPOINTMENT POLICY
IOP services consist of four hours of treatment, four days per week. Outpatient services range from thirty minutes to an hour of scheduled treatment. Appointments are scheduled with the frequency determined by your therapist. We respect the time reserved for you and do not overbook appointments. **If you must cancel an appointment, you must contact our office during normal business office hours - with a minimum of 24 hours' notice - prior to your appointment. A $55 no-show fee will be applied if you fail to cancel your appointment with proper notice or do not show up for your appointment**. (Exception: you and your therapist agree that the circumstances did not permit advance notice.) After three "No-Shows" or late cancellations/appointment changes, your therapist will evaluate your privileges of scheduling future appointments. Please note that health insurance policies do not cover fees for missed/cancelled or "No-Show" appointments.

PAYMENT POLICY

Payment is expected at the time of service, unless another payment agreement is established. In circumstances of unusual financial hardship, a payment plan may be available to you.

It is your responsibility to ensure that your individual insurance policy covers mental health visits. You are responsible for paying all charges for services provided, regardless of payments from your insurance company. You are responsible for any and all visits or services not covered or partially covered by your insurance plan. This includes all payments, including co-pays, where appropriate. If payment is not made at the time of service, a $15.00 fee will be added.

For high deductible insurance plans, payment will be due when HPA/LiveWell receives notice from your insurance carrier that the visit was applied to your deductible.

Should your insurance policy lapse for any reason while receiving treatment at HPA/LiveWell, you will be responsible for all outstanding payments. Should any visits take place during a lapse in your policy, you will be billed at the full amount.

If you have an outstanding balance for services provided but not covered, you will not be able to make subsequent appointments until payment is made.

Please be advised there is a fee of $0.20 per page to copy your records. This fee is due when the records are received.

Our administrative team and Practice Administrator will be happy to answer any questions you have regarding this policy.

CONSENT FOR SERVICES

I, _____, authorize HPA/LiveWell to provide services to the individual named below. I understand that the services may include a variety of those listed above and I am aware that participation in the named services is voluntary. I may limit or end services at any time.

I have read and understand the Informed Consent for Outpatient Services and by signing below agree to the policies listed within.

PATIENT NAME: _____
(Please Print)

PARENT/GUARDIAN NAME: _____
(If Applicable)

SIGNATURE: _____ DATE: _____

HPA LiveWell