BIOPSYCHOSOCIAL INTAKE ASSESSMENT & CLIENT INFORMATION - MINORS

Demographic Information

****Please include a picture of Parents/Guardian's Driver's License**

Name: _____

Date: _____ DOB: _____ Age: _____ Gender: _____

Street Address:

_____

City: _____ State: _____ Zip Code: _____

Name of parent(s)/guardian(s) who have legal custody of child:

_____

* *Address if parent/guardian lives in another residence:*
Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number(s): _____
Is it ok to leave a voicemail? *YES* *NO*

Email Address: _____
Is it ok to email you? *YES* *NO*

How were you introduced to us? _____

How Have We Come to Meet?

What are the 3 biggest concerns you have for your child right now? How long have each been going one?

1. _____
2. _____
3. _____

What do you think your child would say their biggest concern(s) is/are?

_____

_____

MRTherapy, LLC * Michele Ramey, LMFT * 702-854-2168
851 S Rampart Blvd, Suite 130
Las Vegas, NV 89145

What solutions (helpful or unhelpful) have you tried to resolve the above concerns?

_____

_____

_____

Have you or your child(ren) had therapy in the past? If so, please provide treatment providers names, dates of service, what your child was seen for, and results.

_____

_____

Change is Coming…

What are your expectations from therapy and the therapist?

_____

_____

List concrete changes you would like to see happen during the course of therapy:

_____

_____

What other things would you like to see change in your life and your family's life?

_____

_____

Do you foresee any obstacles to achieving your goals/changes?

_____

_____

How long will therapy need to last to achieve the changes/goals you want? Write down a target date: _____

List 5 strengths about your child, give examples of each:

1. _____
2. _____
3. _____
4. _____
5. _____

Medical Background

Has your child ever received psychiatric services before? YES NO

MRTherapy, LLC * Michele Ramey, LMFT * 702-854-2168
851 S Rampart Blvd, Suite 130
Las Vegas, NV 89145

If yes, how long ago, with whom, for what, and results:

Many parents have opinions on psychiatric medications, what are yours?

Does your child have any allergies (food, environmental, medicinal, animal, etc.)

Any current or past medical issues, hospitalizations, accidents, injuries or surgeries? If yes, for what?

Is your child presently under a physician's care? If so, for what?

List medications (over the counter & prescribed), nutritional or herbal supplements, alternative treatments (acupuncture, chiropractic, etc.) your child is taking/doing and reasons:

Tell us about the pregnancy of your child (full term, preemie, any complications during pregnancy or at birth, environment and situations during pregnancy and birth).

Tell us about your child's development milestones (delayed, on time, early)

Important Questions We Must Ask

Has your child ever had thoughts of killing themselves? YES NO
If yes, please explain:

Has your child ever planned on killing themselves? YES NO

MRTherapy, LLC * Michele Ramey, LMFT * 702-854-2168
851 S Rampart Blvd, Suite 130
Las Vegas, NV 89145

If yes, please explain:

_____

_____

Has your child ever attempted to kill themselves? YES NO
If yes, please explain:

_____

_____

Has anyone in your family or close to you died by suicide? YES NO
If yes, please explain:

_____

_____

Has your child ever felt like they wanted to seriously hurt or kill someone else?
If yes, please explain: YES NO

_____

_____

Do you have weapons in your home or access to weapons? YES NO
If yes, who has access to them and what are the safety protocols around them?

_____

_____

Is there any past or present abuse or violence? YES NO
If so, please explain:

_____

_____

Is your child currently using any illegal drugs or is the reason you are seeking therapy services substance related?

_____

_____

Has your child ever witnessed or experienced a trauma? Have reoccurring nightmares, flashbacks, or avoids anything that is uncomfortable or painful? If so, please explain:

_____

_____

Are you concerned your child may see or hear things that don't appear to be real? If so, please explain:

_____

_____

MRTherapy, LLC * Michele Ramey, LMFT * 702-854-2168
851 S Rampart Blvd, Suite 130
Las Vegas, NV 89145

Has your child even been arrested, been involved with the juvenile justice system, or is engaging in behaviors that put them at risk? If so, please explain?

_____

_____

Do you have any concerns about your child's sexuality, gender or sexual development?

_____

_____

Education, Responsibility, Recreation and Leisure

What school does your child attend? _____

What grade is your child in? _____

How are your child's grades? _____

Has your child ever been held back or received specialized academic services? If so, for what?

_____

What concerns if any do you have about your child's education or schooling (grades, peers, relationships with teachers, etc)?

_____

_____

What would your child say they likes and dislike about school:
Likes: _____
Dislikes: _____

What responsibilities does your child have at home?

_____

_____

If your child is age 16 yr. and above what skills do you think your child needs to be independent? How are they learning them? What else do they need to gain independence?

_____

_____

What other responsibilities or skills would you like to see your child have/achieve?

_____

_____

Does your child have their own cell phone? YES NO

What are the rules around your child's cell phone use? Who enforces those rules?

_____

Understanding Your Family

** Space left for therapist to draw family tree (genogram)*

Parent's marital status:

Married Divorced Never Married Separated Domestic Partners Widowed

If 1 or both parents are absent, if so for how long and reason for absences:

_____

_____

If parents are not together please describe the parents' relationship with one another:

_____

_____

Who lives in the house with the child?

_____

_____

If parents are not together, who lives in the other house with the child?

_____

_____

Does your family have any pets? If yes, names, types and relationship to each pet:

_____

_____

List 5 or more strengths of your family:

_____

_____

Is there anything that gets in the way of your family being the way you want it to be?

_____

_____

MRTherapy, LLC * Michele Ramey, LMFT * 702-854-2168
851 S Rampart Blvd, Suite 130
Las Vegas, NV 89145

Name, relationship and description of relationship below:
Parent 1:

_____

Parent 2:

_____

Step-parents or parent's significant other:

_____

Siblings: Age, Name and Sex:

1. Sibling 1

   _____
2. Sibling 2

   _____
3. Sibling 3

   _____
4. Sibling 4

   _____

Other important relationships:

_____

_____

Does your family belong to any religious or spiritual groups? YES NO
If yes, what is your level of involvement?

_____

_____

Who else do you consider to be part of or supportive to your family (people or affiliations):

_____

_____

Is there anything else that you think is important for me to know about your child?

_____

_____

_____

_____

THERAPY CONSENT, POLICIES, & AGREEMENT
PART I: THERAPEUTIC PROCESS

BENEFITS/OUTCOMES: The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). Participating in therapy may include benefits such as the resolution of presenting problems as well as improved intrapersonal and interpersonal

relationships. The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope with problems related to work, family, personal, relational, etc. Participating in therapy can lead to greater understanding of personal and relational goals and values. This can increase relational harmony and lead to greater happiness. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of therapy.

EXPECTATIONS: In order for clients to reach their therapeutic goals, it is essential they complete tasks assigned between sessions. Therapy is not a quick fix. It takes time and effort, and therefore, may move slower than your expectations. During the therapy process, we identify goals, review progress, and modify the treatment plan as needed. According to the parenting plan, biological parents who have decision making for non-medical services are expected for the intake session prior to scheduling any minors. Parents are also required to engage in Parenting sessions every 3-4 sessions during treatment.

RISKS: In working to achieve therapeutic benefits, clients must take action to achieve desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and making changes in relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work collaboratively toward a desirable outcome; however, it is possible that the goals of therapy may not be reached.

STRUCTURE OF THERAPY:

- **Intake Phase** – During the first session, therapeutic process, structure, policies and procedures will be discussed. We will also explore your experiences surrounding the presenting problem(s).
- **Assessment Phase** – The initial evaluation may last 2-4 sessions. During this assessment phase, I will be getting to know you. I will ask questions to gain an understanding of your worldview, strengths, concerns, needs, relationship dynamics, etc. During this relationship building process, I will be gathering a lot of information to aid in the therapeutic approach best suited for your needs and goals. If it is determined that I am not the best fit for your therapeutic needs, I will provide referrals for more appropriate treatment.
- **Goal Development/Treatment Planning** – After gathering background information, we will collaborate to identify your therapeutic goals. If therapy is court ordered, goals will encompass your goals and court ordered treatment goals, based on documentation from the court (please provide any court documents). Once each goal is reached, we will sign off on each goal and you will receive a copy.
- **Intervention Phase** – This phase occurs anywhere from session two until graduation/discharge/termination. Each client must actively participate in therapy sessions, utilize solutions discussed, and complete assignments between sessions. Progress will be reviewed, and goals adjusted as needed.
- **Graduation/Discharge/Termination** – As you progress and get closer to completing goals, we will collaboratively discuss a transition plan for graduation/discharge/termination.

LENGTH OF THERAPY: Therapy sessions are typically weekly or biweekly for 50 minutes depending upon the nature of the presenting challenges. Brainspotting therapy sessions are weekly or biweekly for 60+ minutes. Intensives are 1.5-3 hours of therapy weekly or bi-monthly. It is difficult to initially predict

how many sessions will be needed. We will collaboratively discuss from session to session what the next steps are and how often therapy sessions will occur.

APPOINTMENTS AND POLICIES:

Consistency Policy:

Engaging in mental health therapeutic services is an investment in your total well-being and is most effective and life-changing with consistency and commitment. Your therapeutic hour is held exclusively for them, and to maintain therapeutic consistency sessions can be rescheduled per this office's same week reschedule policy. You may reschedule your session within the same 4-day business week (Sunday through Wednesday). For example, if the session is on Tuesday you can reschedule between Wednesday of the same week. A reschedule request must be made 24 hours in advance within the Sunday- Wednesday time frame. Reschedule requests must be in writing by either text or email. This office is closed Thursday-Saturday, voicemails, emails, and text messages may not be checked until the following Sunday. Thus, reschedule requests must be made between Sunday- Wednesday. For example, a Sunday's session reschedule request must be made on or before the previous Wednesday. There will be every attempt to find an appointment time to accommodate your reschedule request, but it cannot guarantee that space is available for your requested reschedule. Without the 24 hours in advance written reschedule request and new appointment time you will be responsible for the full session fee. Your card on file will be charged on the same business day of your missed session. Failure to arrive on time to a session means you will still be charged for the full session fee regardless of your arrival time to the session. Keep in mind this office is not responsible to remind the client of the consistency policy before charging for missed sessions or no-shows**.** _____Initial

Session Cancellation Waiver:

You will receive two waiver cancellations per year free of charge of no show or cancelation no reschedule fees. You may use these at any time. If the clinician has to cancel a session with you: you will not be charged. If you find you are in need of an extended break from therapy due to unplanned circumstances or other situations that arise it will be discussed on an individual basis at the clinician's discretion. If your break is longer than 2 weeks, they will have the option to be removed from the schedule and reschedule the week of your return**.** _____Initial

Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I may periodically take time off for vacation, seminars, and/or become ill. Attempts will be made to give adequate notice of these events. If I am unable to contact you directly, a colleague may contact you to cancel or reschedule an appointment. _____Initial

FEES: The fee for each therapy session is $150-200. Intensives start at $250. Payment is due at the time of service. Acceptable forms of payment are credit/debit card, which has a $6-10 processing fee. Exact-amount cash or check (insufficient-funds checks will be returned upon full payment of the original amount plus $25 for any returned check) are permitted if mailed and

received prior to the appointment. Some HSA credit cards are accepted. If your card is denied be prepared to have alternative payment available otherwise you will be charged for the full session as it will be accounted for a late cancellation appointment within 24 hours due to insufficient payment. In the event that a scheduled appointment time is missed or cancelled less than 24 hours, please refer to the "Appointments and Policies" policy above. _____Initial

The clinician reserves the right to terminate the counseling relationship if more than 3 sessions are missed without proper notification. _____Initial

In the case we need to collect unpaid payments, a collection agency may be utilized. _____Initial

The clinician charges her hourly rate in quarter hours for phone calls over 10 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. All costs for services outside of session will be billed. ***I understand that each time I schedule an appointment with Michele Ramey Therapy, I am entering into a contract for professional time and services with my therapist. A credit card on file for payment is required. Credit card information is stored in a triple encrypted merchant services system for my protection. Payment is requested at the beginning of the session. All major credit cards are accepted. Checks should be made out to *Michele Ramey*. If payment is not made at the time of the session, I give permission for Michele Ramey of MRTherapy, LLC to charge my credit card on file for counseling session fees. I give permission for the credit card on file to be charged for missed session fees, phone consultations and additional counseling services. **_____Initial** ***

In-home/on-site, and telehealth therapy services offer people comfort and flexibility. They are offered at a two-hour rate (i.e. your session fee times two). For on-site therapy, cost for travel is based on the regular hourly rate and is determined by the time it takes to travel from the office to the client's home or requested place of session and return trip. Time is configured by tracking and logging actual time via internet sites such as Google, Bing, Mapquest, etc. to determine travel time. If the location is takes longer than 30minutes to and 30 minutes from location, an additional fee may be required.

TRIAL, COURT ORDERED APPEARANCES, LITIGATION: Michele Ramey, LMFT is not a custody evaluator and cannot make any recommendations on custody. Due to the sensitive nature of divorce and all potential issues that may rise I have specific policies in place. Rarely, but on occasion, a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. In order to protect your confidentiality, I strongly suggest not being involved in the court. If I get called into court by you or your attorney, or as a subpoena, I will testify as a fact witness only, you will be charged a fee of $2500 prior to any work being done. Court related professional time, including but not limited to court letters, depositions or communication to lawyers, is billable at $300 billable at 15-minute increments to include travel time, court time, preparing documents, etc. Checks, cash and all major credit cards are acceptable to pay for hourly fees as well.

COPIES OF MEDICAL RECORDS: Should you request a copy of your medical records; the cost is $2.50 per page. Court medical records do not apply, please see Financial Fee Agreement for information on court fees. Payment for your medical records will be due prior or upon receipt and can be picked up at the office. Please allow at least 1 week to prepare medical records.

PHONE CONTACTS AND EMERGENCIES: Therapy Office hours are from Sunday-Wednesday 9am-5pm CST. If you need to contact the clinician for any reason, please call 702-854-2168, leave a voicemail, and a return call will be made as soon as possible. MRTherapy, LLC is not an emergency services agency. In case of an emergency, you can access emergency assistance by calling the National Suicide Prevention Lifeline at 1-800-273-8255. If either you or someone else is in danger of being harmed, dial 911. Visit https://naminevada.org/crisis-info/ for additional crisis information in Nevada.

PART II: CONFIDENTIALITY*:*

Anything said in therapy is confidential and may not be revealed to a third party without written authorization, ***except*** for the following limitations:

- **Child Abuse**: Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, I am required by law to report this to the appropriate authority.
- **Vulnerable Adult Abuse**: Vulnerable adult abuse or neglect. If information is revealed about vulnerable adult or elder abuse, I am required by law to report this to the appropriate authority.
- **Self-Harm**: Threats, plans or attempts to harm oneself. I am permitted to take steps to protect the client's safety, which may include disclosure of confidential information.
- **Harm to Others**: Threats regarding harm to another person. If you threaten bodily harm or death to another person, I am required by law to report this to the appropriate authority.
- **Court Orders & Legal Issued Subpoenas**: If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone. If I cannot get in touch with you by phone, I will send you written correspondence. If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.
- **Law Enforcement and Public health**: A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability; to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or action; limited information (such as name, address DOB, dates of treatment, etc.) to a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; and information that your clinician believes in good faith establishes that a crime has been committed on the premises.
- **Governmental Oversight Activities**: To an appropriate agency information directly relating to the receipt of health care, claim for public benefits related to mental health, or qualification for, or receipt of, public benefits or services when your mental health is integral to the claim for benefits

or services, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

- **Upon Your Death**: To a law enforcement official for the purpose of alerting of your death if there is a suspicion that such death may have resulted from criminal conduct; to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.
- **Victim of a Crime**: Limited information, in response to a law enforcement official's request for information about an you if you are suspected to be a victim of a crime; however, except in limited circumstances, we will attempt to get your permission to release information first.
- **Court Ordered Therapy**: If therapy is court ordered, the court may request records or documentation of participation in services. I will discuss the information and/or documentation with you in session prior to sending it to the court.
- **Written Request**: Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given in lieu of actual "psychotherapy/progress notes", except if the third party is part of the medical team. If therapy sessions involve more than one person, each person over the age of 18 MUST sign the release of information before information is released.
- **Fee Disputes**: In the case of a credit card dispute, I reserve the right to provide the necessary documentation (i.e., your signature on the "Therapy Consent & Agreement" that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on account, a bill will be sent to the home address on the intake form unless otherwise noted.
- **Couples Counseling & "No Secret" Policy:** When working with couples, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a "secret" that is detrimental to the couple's therapy goal. If one partner requests that I keep a "secret" in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists as our work and your goals then become counter-productive. However, if one party requests a copy of couples or family therapy records in which they participated, an authorization from each participant (or their representatives and/or guardians) in the sessions before the records can be released.
- **Dual Relationships & Public**: Our relationship is strictly professional. In order to preserve this relationship, it is imperative that there is no relationship outside of the counseling relationship (ie: social, business, or friendship). If we run into each other in a public setting, I will not acknowledge you as this would jeopardize confidentiality. If you were to acknowledge me, your confidentiality could be at risk.
- **Social Media**: No friend requests on our personal social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) will be accepted from current or former clients. If you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform. They are not confidential, nor are they monitored, and may become part of medical record.
- **Policy on Confidentiality for Child Clients**: In working with child clients, though legally the parent(s) or legal guardian(s) of child clients age-appropriate privacy is essential relationship and setting for a child's therapy, we do honor what the child does or says in our sessions as confidential while providing parents and/or legal guardians

summaries of treatment goals, plan and progress as well as recommendations. _____Initial

- **Treatment of Minors in Counseling**: Individuals (under age 18) in therapy are seen only with permission from his or her parents or guardian. A child will be seen only with written permission and/or acknowledgement of both parents. Children of divorce must have signed permission from BOTH parents to attend counseling. Participation from both parents, regardless of the custodial arrangement, is the preferred practice of this office. **A COPY OF THE PARENTING PLAN MUST BE INCLUDED IN THE CLIENT FILE INDICATING THE CUSTODIAL ARRANGEMENT PRIOR TO THE FIRST SESSION WITH THE MINOR CHILD.** In any custodial arrangement, both parents have the right to contact the therapist and inquire regarding their child's treatment progress (unless otherwise indicated by the courts). _____Initial
- **Age of Majority:**

1) **NRS 129.010 Age of majority.** All persons of the age of 18 years who are under no legal disability, and all persons who have been declared emancipated pursuant to NRS 129.080 to 129.140, inclusive, are capable of entering into any contract, and are, to all intents and purposes, held and considered to be of lawful age.

2) **NRS 129.030 Consent for examination and treatment.**

1. Except as otherwise provided in NRS 450B.525, a minor may give consent for the services provided in subsection 2 for himself or herself or for his or her child, if the minor is:

(a) Living apart from his or her parents or legal guardian, with or without the consent of the parent, parents or legal guardian, and has so lived for a period of at least 4 months;

(b) Married or has been married;

(c) A mother, or has borne a child; or

(d) In a physician's judgment, in danger of suffering a serious health hazard if health care services are not provided.

2. Except as otherwise provided in subsection 4 and NRS 449A.551 and 450B.525, the consent of the parent or parents or the legal guardian of a minor is not necessary for a local or state health officer, board of health, licensed physician or public or private hospital to examine or provide treatment for any minor, included within the provisions of subsection 1, who understands the nature and purpose of the proposed examination or treatment and its probable outcome, and voluntarily requests it. The consent of the minor to examination or treatment pursuant to this subsection is not subject to disaffirmance because of minority.

3. A person who treats a minor pursuant to subsection 2 shall, before initiating treatment, make prudent and reasonable efforts to obtain the consent of the minor to communicate with his or her parent, parents or legal guardian, and shall make a note of such efforts in the record of the minor's care. If the person believes that such efforts would jeopardize treatment necessary to the minor's life or necessary to avoid a serious and immediate threat to the minor's health, the person may omit such efforts and note the reasons for the omission in the record.

4. A minor may not consent to his or her sterilization.

5. In the absence of negligence, no person providing services pursuant to subsection 2 is subject to civil or criminal liability for providing those services.

6. The parent, parents or legal guardian of a minor who receives services pursuant to subsection 2 are not liable for the payment for those services unless the parent, parents or legal guardian has consented to such health care services. The provisions of this subsection do not relieve a parent, parents or legal guardian from liability for payment for emergency services provided to a minor pursuant to NRS 129.040.

3) **NRS 129.040 When person standing in loco parentis may give consent for minor's emergency hospitalization or medical attention.** Notwithstanding any other provision of law, in cases of emergency in which a minor is in need of immediate hospitalization, medical attention or surgery and, after reasonable efforts made under the circumstances, the parents of such minor cannot be located for the purpose of consenting thereto, consent for such emergency attention may be given by any person standing in loco parentis to such minor.

(Added to NRS by 1965, 170)

4) **NRS 129.050 Abuse of controlled substance: Treatment authorized without consent of parent or guardian under certain circumstances.**

1. Except as otherwise provided in NRS 449A.551 and 450B.525, any minor who is under the influence of, or suspected of being under the influence of, a controlled substance:

(a) May give express consent; or

(b) If unable to give express consent, shall be deemed to consent,

Ê to the furnishing of hospital, medical, surgical or other care for the treatment of substance use disorders or related illnesses by any public or private hospital, medical facility, facility for the dependent, other than a halfway house for persons recovering from alcohol and other substance use disorders, or any licensed physician, and the consent of the minor is not subject to disaffirmance because of minority.

2. Immunity from civil or criminal liability extends to any physician or other person rendering care or treatment pursuant to subsection 1, in the absence of negligent diagnosis, care or treatment.

3. The consent of the parent, parents or legal guardian of the minor is not necessary to authorize such care, but any physician who treats a minor pursuant to this section shall make every reasonable effort to report the fact of treatment to the parent, parents or legal guardian within a reasonable time after treatment.

- **Electronic Communication: If you need to contact me outside of our sessions, please do so via phone.**
    - **Clients often use text or email as a convenient way to communicate in their personal lives. However, texting introduces unique challenges into the therapist–client relationship.** Texting is not a substitute for sessions. **Texting is not confidential**. Phones can be lost or stolen. DO NOT communicate sensitive information over text. The identity of the person texting is unknown as someone else may have possession of the client's phone.

- **Do not use email for emergencies**. In the case of an emergency call 911, your local emergency hotline or go to the nearest emergency room. Additionally, e-mail is not a substitute for sessions. If you need to be seen, please call to book an appointment.
- **E-mail is not confidential.** Do not communicate sensitive medical or mental health information via email. Furthermore, if you send email from a work computer, your employer has the legal right to read it. E-mail is a part of your medical record.

- **Sessions Outside the Office:** From time to time, clients like to meet in an alternate location (i.e., their home, in public, or somewhere more conducive for them). We may be able to accommodate this request, however, this can put your confidentiality at risk.

PART III: REASONS I DO NOT ACCEPT INSURANCE

- **Reduced Ability to Choose:** Most health care plans today (insurance, PPO, HMO, etc.) offer little coverage and/or reimbursement for mental health services. Most HMOs and PPOs require "preauthorization" before you can receive services. This means you must call the company and justify why you are seeking therapeutic services in order for you to receive reimbursement. The insurance representative, who may or may not be a mental health professional, will decide whether services will be allowed. If authorization is given, you are often restricted to seeing the providers on the insurance company's list. Reimbursement is reduced if you choose someone who is not on the contracted list; consequently, your choice of providers is often significantly restricted.
- **Pre-Authorization and Reduced Confidentiality:** Insurance typically authorizes several therapy sessions at a time. When these sessions are finished, your therapist must justify the need for continued services. Sometimes additional sessions are not authorized, leading to an end of the therapeutic relationship even if therapeutic goals are not completely met. Your insurance company may require additional clinical information that is confidential in order to approve or justify a continuation of services. Confidentiality cannot be assured or guaranteed when an insurance company requires information to approve continued services. Even if the therapist justifies the need for ongoing services, your insurance company may decline services. Your insurance company dictates if treatment will or will not be covered. Note: Personal information might be added to national medical information data banks regarding treatment.
- **Negative Impacts of a Psychiatric Diagnosis:** Insurance companies require clinicians to give a mental health diagnosis (i.e., "major depression" or "obsessive-compulsive disorder") for reimbursement. Psychiatric diagnoses may negatively impact you in the following ways:

1. Denial of insurance when applying for disability or life insurance;
2. Company (mis)control of information when claims are processed;
3. Loss of confidentiality due to the increased number of persons handling claims;
4. Loss of employment and/or repercussions of a diagnosis in situations where you may be required to reveal a mental health disorder diagnosis on your record. This includes but is not limited to: applying for a job, financial aid, and/or concealed weapons permits.
5. A psychiatric diagnosis can be brought into a court case (i.e.,: divorce court, family law, criminal, etc.).

It is also important to note that some psychiatric diagnoses are not eligible for reimbursement. This is often true for marriage/couple's therapy.

Why Clinicians Do Not Take Insurance: These involve enhanced quality of care and other advantages:

1. You are in control of your care, including choosing your therapist, length of treatment, etc.
2. Increased privacy and confidentiality (except for limits of confidentiality).
3. Not having a mental health disorder diagnosis on your medical record.
4. Consulting with me on non-psychiatric issues that are important to you that aren't billable by insurance, such as learning how to cope with life changes, gaining more effective communication techniques for your relationships, increasing personal insight, and developing healthy new skills.

After reading my position on why I don't accept health insurance, you still may decide to use your health insurance. If you provide me with a list of therapists on your insurance provider list, I will do my best to recommend a therapist for you.

EMERGENCY CONTACT:

It is necessary that **Michele Ramey, LMFT** of **MRTherapy, LLC** has someone to contact on your behalf. In case of an emergency who should we contact?

_____

Full Name Relationship Phone Number(s)

Please check here that you agree and sign below. Thank you.

☐ I agree to allow **MRTherapy, LLC** to contact my emergency contact on my behalf in the case of emergency

_____

Signature Date

PART IV: CONSENT

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with **Michele Ramey, LMFT**. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **Michele Ramey, LMFT** to provide counseling services that are considered necessary and advisable.

2. I authorize the **release of treatment and diagnosis information** (as described in Part III, above) necessary to process bills for services **to my insurance company**, and request payment of benefits to **Michele Ramey, LMFT,** of **MRTherapy, LLC**. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I understand, in the event that fees are not covered by insurance, **Michele Ramey, LMFT,** of **MRTherapy, LLC** may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

3. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Michele Ramey, LMFT to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to **Michele Ramey, LMFT** prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name	Signature	Date

Your signature signifies that you have received a copy of the "Therapy Agreement, Policies and Consent*" for your records.*

Printed Name of Minor Child	DOB	Date

Clinician Signature:_____Date:_____
Michele Ramey, LMFT

PART V: CONSENT (CLIENT'S COPY)

1. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with **Michele Ramey, LMFT**. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize **Michele Ramey, LMFT** to provide counseling services that are considered necessary and advisable.

2. I authorize the **release of treatment and diagnosis information** (as described in Part III, above) necessary to process bills for services **to my insurance company**, and request payment of benefits to **Michele Ramey, LMFT,** of **MRTherapy, LLC**. I acknowledge that I am financially responsible for payment whether or not covered by insurance. I understand, in the event that fees are not covered by insurance, **Michele Ramey, LMFT,** of **MRTherapy, LLC** may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

3. **Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Michele Ramey, LMFT to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to **Michele Ramey, LMFT** prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name	Signature	Date

Your signature signifies that you have received a copy of the "Therapy Agreement, Policies and Consent*" for your records.*

Printed Name of Minor Child	DOB	Date

Clinician Signature:_____Date:_____
Michele Ramey, LMFT

MRTherapy, LLC * Michele Ramey, LMFT * 702-854-2168
851 S Rampart Blvd, Suite 130
Las Vegas, NV 89145

TECHNOLOGY ASSISTED COUNSELING (TAC)
CONSENT, POLICIES, & AGREEMENT

This form is in **addition** to the regular Therapy, Policies, Agreement and Consent Form and Notice of Privacy Practices for Protected Health Information commonly known as HIPAA. You must sign both in order to participate in Technology Assisted Counseling (TAC) sessions. TAC incorporates email, phone and video counseling. Prior to engaging in TAC an assessment/consultation will be done to assure that TAC is an appropriate form of counseling. This is to inform you about what you can expect regarding your participation in TAC counseling.

Benefits:
The benefits to TAC counseling are:

1. The ability to expand your choice of service provider.
2. More convenient counseling options including location, time, no driving, etc.
3. Reduces the overall cost and time of therapy due to not having to drive to and from and office.
4. Ability to have real time monitoring and reduces the wait time for scheduling office appointments.
5. Increased availability of services to homebound clients. clients with limited mobility, and clients without convenient transportation options.

Limitations:
It is important to note that there are limitations to TAC counseling that can affect the quality of the session(s). These limitations include but are not limited to the following:

1. I cannot see you, your body language, or your non-verbal reactions to what we are discussing.
2. Due to technology limitations I may not hear all of what you are saying and may need to ask you to repeat things.
3. Technology might fail before or during the TAC counseling session.
4. Although every effort is made to reduce confidentiality breaches, breaches may occur for various reasons.
5. To reduce the effect of these limitations, I may ask you to describe how you are feeling, thinking, and/or acting in more detail than I would during a face-to-face session. You may also feel that you need to describe your feelings, thoughts, and/or actions in more detail than you would during a face-to-face session.

Logistics:
When I provide phone/video-counseling sessions, I will call you at our scheduled time or send you a link for our secure and HIPAA compliant video session. I expect that you are available at our scheduled time and are prepared, focused and engaged in the session. I am calling you from a private location where I am the only person in the room. You also need to be in a private location where you can speak openly without being overheard or interrupted by others to protect your own confidentiality. If you choose to be in a place where there are people or others can hear you, I cannot be responsible for protecting your confidentiality. Every effort MUST be

made on your part to protect your own confidentiality. I suggest you wear a headset to increase confidentiality and also increase the sound quality of our sessions. Please know that I cannot guarantee the privacy or confidentiality of conversations held via phone, as phone conversations can be intercepted either accidentally or intentionally. Please assure you reduce all possibilities of interruptions for the duration of our scheduled appointment.

Please know that per best practices and ethical guidelines I can only practice in the state(s) I am licensed in. That means wherever you reside I must be licensed. You agree to inform me if your therapy location has changed or if you have relocated your domicile to a different jurisdiction.

Connection Loss During Phone Sessions: If we lose our phone connection during our session, I will call you back immediately. Please also attempt to call me at 702-854-2168 if I cannot reach you. If we are unable to reach each other due to technological issues, I will attempt to call you 2 times. If I cannot reach you, I will remain available to you during the entire course of our scheduled session. Should you contact me back and there is time left in your session we will continue. If the reason for a connection loss i.e., technology, your phone battery dying, bad reception, etc. occurs on your part, you will still be charged for the entire session. If the loss for connection is a result of something on my end, I will call you from an alternate number. The number may show up as restricted or blocked please be sure to pick it up.

Connection Loss During Video Sessions: If we lose our connection during a video session, I will call you to troubleshoot the reason we lost connection. If I cannot reach you, I will remain available to you during the entire course of our scheduled session. Should you contact me back and there is time left in your session we will continue. If the reason for a connection loss i.e., technology, battery dying, bad reception, etc. occurs on your part, you will still be charged for the entire session. If the loss for connection is a result of something on my end, we can either complete our session via. phone or plan an alternate time to complete the remaining minutes of our session.

Please list your main number and an alternate number below.

_____

Number(s)

Recording of Sessions:
Please note that recording, screenshots, etc. of any kind of any session is not permitted and are grounds for termination of the client-therapist relationship.

Payment for Services:
Payments for services must be made **prior** to each session. I will charge your card on file or send you an invoice. Payment is to be completed prior to our session.

Cancellation Policy:
If you must cancel or reschedule an appointment, 24-hour advance notice is required, otherwise you will be held financially responsible. Should you cancel or miss an appointment with

notification less than 24 hours this will result in being charged the ***full fee*** for your missed appointment. Cancellations must be communicated by phone; NOT email or text. If clients have more than 2 cancellations during the course of treatment/therapy the therapist and client will address the need for ongoing therapy. Should a client express and wish and/or desire to continue a client may be asked to pre-pay for sessions when they are scheduled. If the client cancels or misses the session with less than 24 hours' notice and the session is pre-paid, this follows the cancelation guidelines and the payment will not be reimbursed for the missed or canceled session less than 24 hours. Phone/video sessions should be treated as regular in office sessions. If you are late getting on the phone, are unable to talk at our scheduled time, your battery has died and you are unable to access another confidential place to talk, or any other variable that would have you not be able to attend our session please know that you will be charged for the session. Please make the necessary arrangements you need to be available and present for your session.

Emergencies and Confidentiality:

I request an emergency contact for you. Please list the person's first and last name, relationship and phone number(s) of your emergency contact:

_____

Full Name Relationship Number(s)

I also request the address from which you are calling and the number to your local police department including area code in the area in which you are located during the time of our call.

_____

Street Address

_____

City State Zip Code

_____

City and State of Local Police Department Phone Number

If a situation occurs where we are talking and get disconnected and you are in crisis, you agree to call 911, go to your local emergency room immediately or contact the National Suicide Hotline at 800-784-2433.

If I have concerns about your safety at ***any*** time during a phone session, I will need to break confidentiality and call 911 (if located in the same county or emergency services in the area you are located at the time of the call) and/or your emergency contact immediately. Please note that everything in our informed consent that you signed, including all the confidentiality exceptions, still applies during phone/video sessions.

Consent to Participate in TAC Sessions:

By signing below, you agree that you have read and understand all of the above sections of TAC informed consent. You agree that you also understand the limitations associated with participating in TAC counseling sessions and consent to attend sessions under the terms described in this document.

Client's Name: _____ Date: _____

Legal Guardian's Signature: _____ Date: _____

Client's Name: _____ Date: _____

Client's Signature: _____ Date: _____

Therapist's Signature: _____Date: _____
Michele Ramey, LMFT

MRTherapy, LLC * Michele Ramey, LMFT * 702-854-2168
851 S Rampart Blvd, Suite 130
Las Vegas, NV 89145

Health Insurance Portability Accountability Act (HIPAA)

Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
- I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

- If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Las Vegas Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
- If I know or have reasonable cause to suspect that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Las Vegas Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
- If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment –*** I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- ***For Operations*** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Patient's Rights:

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be

completed. Furthermore, there is a copying fee charge of $1.50 per page. Please make your request well in advance and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- ***Right to a Copy of This Notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Las Vegas Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Client/Legal Guardian Signature : _____ Date: _____

Printed Name:_____ Date:_____

MRTherapy, LLC * Michele Ramey, LMFT * 702-854-2168
851 S Rampart Blvd, Suite 130
Las Vegas, NV 89145

Client/Legal Guardian Signature : _____ Date: _____

Printed Name:_____Date:_____

Therapist's Signature:_____Date:_____
Michele Ramey, LMFT

MRTherapy, LLC * Michele Ramey, LMFT * 702-854-2168
851 S Rampart Blvd, Suite 130
Las Vegas, NV 89145

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

I, (Client's Name)_____ **DOB:**_____

hereby give my permission to **MRTherapy, LLC**, to release or request from a third-party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in federal law.

This information will be released/requested upon request to the following:

To/From:

_____

First and last name, phone, and address of person(s)

The type of information to be disclosed/requested is as follows:

To Be Released * *from MRTherapy, LLC*	**To Be Requested** * *from third parties*
____Treatment Plans	____Treatment Plans
____Progress Notes	____Progress Notes
____Health/Medical Records (if applicable)	____Health/Medical/Academic Records
____Letter(s) of Progress	____Psychological/Psychiatric Evaluations
____Bio Psychosocial Evaluation/Assessment (if applicable)	____Court Documents
__X Verbal Communication	__X Verbal Communication
____Other (Specify): _____	____Other (Specify):

** In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("process notes"), such records may be protected from disclosure under the HIPAA Privacy Rule).*

____(initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to **MRTherapy, LLC**.

____ (initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and **MRTherapy, LLC** will not base my treatment or payment whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

____(initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or **MRTherapy, LLC**. **MRTherapy, LLC** will not be held liable for information disclosed to another party per the client's request.

____(initial) I understand that **MRTherapy, LLC** will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death.) This agreement is subject to revocation in writing at any time.

MRTherapy, LLC * Michele Ramey, LMFT * 702-854-2168
851 S Rampart Blvd, Suite 130
Las Vegas, NV 89145

Release: **Request:**

_____ _____

Signature Client/Next of Kin/Guardian Date **Signature Client/Next of Kin/Guardian Date**

Signature:_____**Date:**_____

Michele Ramey, LMFT

MRTherapy, LLC * Michele Ramey, LMFT * 702-854-2168
851 S Rampart Blvd, Suite 130
Las Vegas, NV 89145

INFORMED CONSENT TO VIDEO RECORD COUNSELING SESSIONS

Video recording are commonly used for consultation, training and research in individual and couple therapy. Videos are used for the purposes of professional training, consultation and/or improving service in individual supervision (between the counselor and their supervisor) and/or group supervision (between the counselor, the supervisor, and other registered therapists). The recording of sessions will likely enhance the effectiveness and quality of treatment but is not required. You may decline to have sessions recorded. Your signature below indicates that you give Michele Ramey, LMFT at MRTherapy, LLC permission to videotape your counseling sessions for training, improving service and supervision purposes and that you understand that: 1. You can request that the video recorder be turned off at any time and may request that the video or any portion thereof be erased. You may terminate this permission to record at any time. 2. The purpose of recording is for use in training and supervision. This will allow the above referenced counselor to consult with his or her assigned supervisor(s) in an individual or group supervision format, who may watch the recording alone or in the presence of other counselors involved in direct supervision. 3. The strictest confidentiality will be maintained, and there will be no sharing of the recorded material beyond the limits of training and supervision. Except for your first name and your voice and/or image on the recording, there will be no information that could identify you. The recording will never knowingly be shared with anyone who knows you. Mental health professionals who may view or hear recorded material of your session are also bound by law and by code of ethics to the same obligation to protect your confidentiality. Except in the context of training and supervision, the existence of this recording will not be discussed with anyone at any time. 4. The recordings will be stored in a secure location and will not be used for any other purpose without your explicit written permission.

_____ _____

Legal Guardian/ Client Name (Please Print) Date

_____

Legal Guardian/ Client Signature

_____ _____

Parent / Guardian Signature Date

_____ _____

Client Decline Signature Date

MRTherapy, LLC * Michele Ramey, LMFT * 702-854-2168
851 S Rampart Blvd, Suite 130
Las Vegas, NV 89145