Counseling by Kate, PLLC

Kate Knapp Lengyel, J.D., M.S., LPC, Mediator

Counselor, Co-parenting Coach, Parent Coach, Parenting coordinator

As of March 16, 2020, Counseling by Kate, PLLC will be conducting all sessions via phone call or video conferencing via Zoom or FaceTime for the foreseeable future due to the severity of the COVID-19 outbreak. During this time, if you would like to continue services with Counseling by Kate, PLLC, you agree to utilize one or more of these means of communication for your therapeutic treatment.

It is important for you to understand the following information regarding these means of communication and how it applies to your treatment, confidentiality and privacy.

_____ (initial) I understand that phone calls and telehealth therapy sessions may be different than in-person sessions. There are potential benefits and risks to this type of therapy.

_____ (initial) I understand that Confidentiality still applies to the notes taken during or after my sessions and that those notes will be secured in a HIPAA compliant manner at the residence of my provider. Neither party (provider nor client) shall record the sessions without written permission.

_____ (initial) I understand that utilizing telephone and/or videoconferencing (through FaceTime or Zoom), is not a completely secure means of conducting sessions and does not meet compliance for protection under federal law. This means that although my provider will take all reasonable precautions to make sessions confidential (be alone while conducting sessions, utilize passcodes and secured internet, etc.) I shall not hold provider or entity liable for any security breaches that result in disclosure of my personal health information (PHI) as protected under the federal law of HIPAA while utilizing these means of conducting sessions unless there is intentional negligence by the provider.

_____ (initial) I understand that if I am not comfortable with waiving my liability and would prefer to utilize HIPAA approved means of conducting sessions at this time that my provider will provide me with referrals that will be able to accommodate this.

_____ (initial) I understand that at this time, all other stipulations in my intake paperwork shall remain in full effect including the Informed Consent, Financial Agreement, Notice of Policies and Practices to Protect the Privacy of Your Health Information (despite the waiver indicated above for phone calls, emails, text messages, and/or video-conferencing via FaceTime/Zoom), Medical Release and Communications Authorization, and Credit Card Authorization.

_____ (initial) I understand that my provider will instruct me on how to utilize the means I choose to conduct sessions with during this time.

My signature below shall act as my legal waiver of any and all liability against Counseling by Kate, PLLC and its agents for any release of my PHI due to unknown or known security breaches of text messages, phone calls, voicemails, emails, or video-conferences (via FaceTime or Zoom) unless there is intentional negligence by Counseling by Kate, PLLC or its agents. I have been informed completely of

the protections I am afforded with regards to my PHI under federal law (HIPAA) and I am choosing to waive those protections in order to utilize text messaging, email, voicemail, phone calls, and/or videoconferences (via FaceTime or Zoom). I, being of sound mind and body, voluntarily agree to waive all liability against the provider and hold harmless, its employees or its agents, for any fault or liability for injuries resulting from the use of the following means of communications with provider: text messaging, email, phone calls, voicemails and/or video-conferencing (via FaceTime or Zoom) of the provider, its employees, or its agents unless there is intentional negligence by the provider, its employees or agents. I am assuming the risks associated with these means of communications with my provider for psychotherapy treatment. This waiver shall remain in effect until I provide written notice of its termination.

In an effort to respect your privacy, please indicate your preferences from the list below by initialing next to the options with which you agree to utilize during your treatment and waive PHI protections as indicated.

_____Yes: leave a voice message, have a phone call or phone session and/or text message on my home phone, mobile phone number or email and/or conduct sessions utilizing video conferencing as indicated below.

Please initial next to the options you AGREE to utilize throughout treatment and waive HIPAA compliance and privacy as indicated above. Please write "NO" next to the items which you do not approve.

_____ (initial) Home phone ( ) _____

_____ (initial) Mobile phone voicemail ( ) _____

_____ (initial) Mobile phone text messaging ( ) _____

_____ (initial) Email _____

_____ (initial) Video Conferencing (circle preference) FaceTime Zoom

_____ (initial) Mobile phone voicemail (minor child) ( ) _____

_____ (initial) Mobile phone text messaging (minor child) ( ) _____

_____ _____ _____

Client name (printed) Client Signature (Parent/Guardian if minor) Date