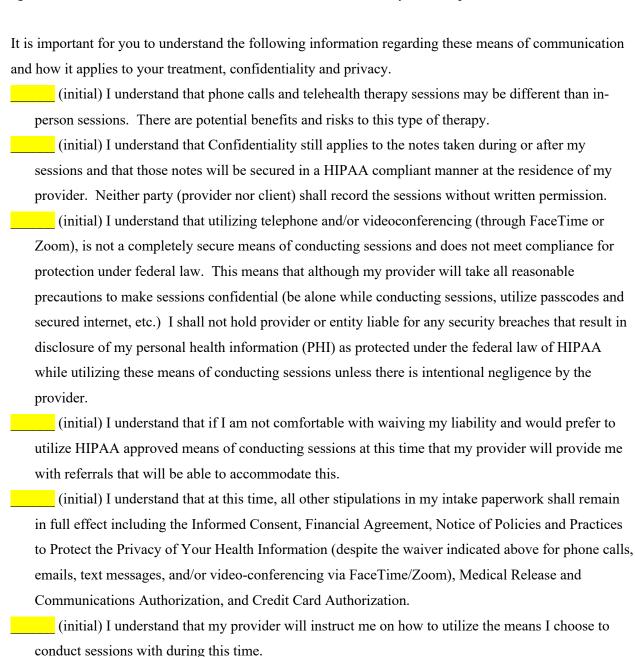
## COUNSELING BY KATE, PLLC

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.



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

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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.

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