Samaritan
HEALING MIND, BODY, SPIRIT

INFORMED CONSENT –Treatment Services (HSS 94.03)

Samaritan is sensitive to the spiritual and faith-based resources that some people want to use as they explore health and well-being. We welcome opportunities to integrate a client's spiritual belief and practices as a part of the therapeutic process. Therapists will not impose their personal belief upon our clients, rather if requested, we work with the belief system of the clients and include discussion of spirituality/religion/faith according to the expressed preference.

PROBABLE BENEFIT OF TREATMENT: If you do not think your needs are being met, you are urged to discuss this with your therapist. This discussion will provide the opportunity to clarify goals or consider the possibility of a referral to another therapist who may better meet your needs.

SIDE EFFECTS OF TREATMENT/Probable consequences of not receiving treatment: The treatment process typically involves identifying and talking about issues that are difficult or painful. It is not unusual to feel like things are getting worse before you feel progress or improvement. Not receiving treatment will include the possibility you will continue to experience similar problems or things may get worse.

PROVIDERS OF TREATMENT: Services are provided by Licensed Masters level Therapists, Master level Therapist-Residents holding a training license provided by the State of Wisconsin, or Master's Level Counseling Interns who are in good standing with their academic university. All Clinical Therapists and their cases are reviewed and supervised by a Clinical Director and/or Supervisor as well as a consulting Clinical Psychologist. Alcohol and Drug services are provided by dual licensed therapist with a specialty in AODA and supervised by an AODA Clinical Supervisor. Samaritan is a training site for Master's level students (interns) in training for counseling and social work. With your permission, one of these interns may be present with your counselor during appointments. Including trainees in your appointments have the added benefit of having more feedback and ideas for your counseling; however, you retain the right to deny the inclusion of trainees.

ALTERNATIVE TREATMENT: Alternative modes of treatment will be discussed during the assessment process, and/or during the course of treatment planning.

RELEASE OF INFORMATION FOR BILLING PURPOSES: I agree that the organization may release to and receive from any insurers, other payers, or other persons, necessary for billing and related purposes. This information may include my identity, diagnosis and prognosis, treatment for mental health and/or alcohol or drug issues and all other information contained in my record to the extent that such records are needed for billing or collection of benefits. I am aware that I have the option to pay for services at the time of my sessions.

TIME PERIOD OF INFORMED CONSENT/RIGHT TO WITHDRAW: Your consent for treatment will last until the goals of treatment have been satisfactorily reached, or you or your therapist elects to terminate treatment. This consent will be renewed every 12 months. You retain the right to withdraw informed consent and terminate treatment at any time. We do ask that you discuss this with your therapist.

NO SHOW: Be aware that if you miss an appointment Samaritan has the right to charge a fee and all future appointments already scheduled will be cancelled to make time available for other clients. If you no show or late cancel for more than two appointments Samaritan Counseling may terminate services.

My signature below indicates that my therapist has explained this informed consent and I am satisfied with my understanding of the treatment process and have been offered a copy of this document. I hereby voluntarily consent to be actively involved in treatment.

_____	_____	_____	_____
Client Signature	Date	Parent/Guardian Signature	Date
_____	_____	_____	_____
Therapist Signature	Date	Parent/Guardian Signature	Date

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FORM CONSENT TO VIDEOTHERAPY[1]

--OFFICE USE--

CLIENT NAME: _____ DOB: _____ MR#: _____

LOCATION OF CLIENT: _____

SAMARITAN LOCATION: _____ DATE CONSENT DISCUSSED: _____

Introduction

"**VideoTherapy Services**" involves the delivery of health care services[2] using electronic communications, information technology or other means between a health care provider employed by or otherwise contracted with SAMARITAN ("**Provider**") and a client who are not in the same physical location. VideoTherapy may be used for diagnosis, treatment, follow-up and/or education, and may include, but is not limited to:

- Electronic transmission of clinical records, photo images, personal health information or other data between a member and a Provider;
- Interactions between a client and Provider via audio, video and/or data communications; and
- Use of output data from clinical devices, sound and video files.

The vendor of the electronic systems used in the provision of VideoTherapy Services has represented that it incorporates industry standard network and software security protocols to protect the privacy and security of health information.

Possible Benefits of VideoTherapy

- Can be easier and more efficient for you to access clinical care and treatment from a Provider.
- You can obtain clinical care and treatment at times that are convenient for you.
- You can interact with a Provider without the necessity of an in-office appointment.

Possible Risks of VideoTherapy

- Information transmitted to your Provider may not be sufficient to allow for appropriate clinical decision making by the Provider.
- The inability of your Provider to conduct certain tests or assessments in-person may in some cases prevent the Provider from providing a diagnosis or treatment or from identifying the need for emergency clinical care or treatment for you.
- Your Provider may not able to provide clinical treatment for your particular condition via VideoTherapy and you may be required to seek alternative care.
- Delays in clinical evaluation/treatment could occur due to failures of the video technology.

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[1] Please note that individual states may have additional and specific requirements for consent to video-conference based therapy including but not limited to special requirements related to the provision of mental health treatment and the confidentiality of such information. As a result, the sample provided above is intended only as a guide.

[2] Consider further defining health care services ("including but not limited to") based upon the types of therapy provided by the Center.

- Security protocols or safeguards could fail causing a breach of privacy.
- Given regulatory requirements in certain jurisdictions, your Provider's treatment options may be limited.

By accepting this Consent to VideoTherapy, you acknowledge your understanding and agreement to the following:

1. I understand that the delivery of health care services via VideoTherapy is an evolving field and that the use of VideoTherapy in my clinical care and treatment may include uses of technology not specifically described in this consent.
2. I understand that while the use of VideoTherapy may provide potential benefits to me, as with any clinical care service no such benefits or specific results can be guaranteed. My condition may not be cured or improved, and in some cases, may get worse.
3. It is my duty to inform my Provider of other in-person or electronic interactions regarding my care that I may have with other health care providers.
4. I understand that my Provider may determine in his or her sole discretion that my condition is not suitable for treatment using VideoTherapy, and that I may need to seek clinical care and treatment in-person or from an alternative source.
5. A variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My Provider has explained the alternatives to my satisfaction.
6. I understand that the same confidentiality and privacy protections that apply to my other health care services also apply to these VideoTherapy services.
7. I agree and authorize my Provider and Center to share information regarding the VideoTherapy exam with other individuals for treatment, payment and health care operations purposes as allowed by law.
8. I understand that I can withhold or withdraw my consent at any time by emailing or providing other such written notification to my Provider with such instruction, without affecting my right to future care or treatment. Otherwise, this consent will be considered renewed upon each new VideoTherapy consultation with my Provider.

Client Consent To The Use of VideoTherapy

I have read this special Consent to VideoTherapy carefully, and understand the risks and benefits of the use of VideoTherapy in the course of my treatment. I have discussed it with my Provider, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of VideoTherapy in my medical care.

I hereby authorize Provider to use VideoTherapy in the course of my diagnosis and treatment.

_____ _____

Client Signature (or person authorized to sign for client) Date

If authorized signer, relationship to client: _____

I have been offered a copy of this consent form (client's initials) _____

_____ _____

Therapist Signature Date

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HIPAA Email Consent Form

When Samaritan sends you an email, or you send Samaritan an email, the information that is sent is not encrypted. This means there is a risk that a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it

Under the Health Insurance Portability and Accountability Act (HIPAA), if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive personal health information via email, a provider may send that patient personal medical information via unencrypted email.

Please select an option from below:

☐ OPTION 1 – **ALLOW** UNENCRYPTED EMAIL
I understand the risks of unencrypted email and hereby give permission to Samaritan to send me personal health information (PHI) via unencrypted email.

☐ OPTION 2 – **DO NOT ALLOW** UNENCRYPTED EMAIL
I do not wish to receive personal health information via email.

_____ _____
Client or Guardian Signature **Date**

_____
Please Print email address (ONLY FOR OPTION 1)

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Demographic Information

Samaritan is a United Way funded agency. United Way seeks to provide services to underserved populations in our community. Minorities and those living in poverty are less likely to seek out support. The information we gather on this form helps us to identify whether we are meeting the needs of all our community members. Thank you for taking the time to provide this information.

Client's Age

☐ 0-3 ☐ 4-5 ☐ 6-12 ☐ 13-18 ☐ 19-21 ☐ 22-39 ☐ 40-59 ☐ 60-79 ☐ 80+

Client's Gender

☐ Female ☐ Male ☐ Other ☐ n/a

Client's Race

☐ American Indian/Alaskan Native
☐ Black/African-American
☐ Asian
☐ Caucasian/White
☐ Hawaiian/Pacific Island
☐ Multiple Races
☐ Other/Unknown
☐ n/a

Client's Ethnicity

☐ Hispanic/Latinx (Cuban, Mexican, Puerto Rican, South or Central American. People of Hispanic/Latinx origin can be of any race.)
☐ Hmong
☐ Other……
☐ Unknown
☐ n/a

Client's Geographic Location by Zip Code

☐ 54911 Appleton
☐ 54912 Appleton
☐ 54913 Appleton
☐ 54914 Appleton
☐ 54915 Appleton
☐ 54922 Bear Creek
☐ 54106 Black Creek
☐ 54110 Brillion
☐ 54113 Combined Locks
☐ 54931 Dale
☐ 54123 Forest Junction
☐ 54131 Freedom
☐ 54942 Greenville
☐ 54944 Hortonville/Medina
☐ 54130 Kaukauna
☐ 54136 Kimberly
☐ 54947 Larson
☐ 54140 Little Chute
☐ 54952 Menasha
☐ 54956 Neenah
☐ 54152 Nichols
☐ 54165 Seymour
☐ 54169 Sherwood
☐ 54170 Shiocton
☐ 54557 Winchester
☐ Other……

Client receives free or reduced lunch at school. ☐ **Yes** ☐ **No**

Client's previous annual household income based on family size (if exceeds please leave blank):

1 person	2 persons	3 persons	4 persons	5 persons	6 persons	7 persons	8 persons
☐ 15,700	☐ 17,950	☐ 20,150	☐ 22,400	☐ 24,200	☐ 26,000	☐ 27,800	☐ 29,600
☐ 26,150	☐ 29,900	☐ 33,600	☐ 37,350	☐ 40,350	☐ 43,350	☐ 46,300	☐ 49,300
☐ 41,850	☐ 47,800	☐ 53,800	☐ 59,750	☐ 64,550	☐ 69,300	☐ 74,100	☐ 78,900