



14000 Crown Court, Ste.101
Woodbridge, VA 22193
Phone # 703-396-7215
Fax # 571-285-5686

9720 Capital Court, Ste. 302
Manassas, VA 20110
Phone # 703-396-8618
Fax # 571-364-8913

6611 Jefferson St
1st Floor
Haymarket, VA 20169
Phone # 571-921-4812
Fax # 703-743-1688

6800 Backlick Road,
Ste. 300
Springfield, VA 22150
Phone # 703-310-7449
Fax # 866-295-9344

19415 Deerfield Ave.
Ste.101
Leesburg, VA 20176
Phone # 571-921-4812
Fax # 703-743-1688

20 Rock Pointe Ln,
Ste. 201
Warrenton, VA 20186
Phone # 703-659-9847
Fax #540-935-2418

TELE-BEHAVIORAL HEALTH (TBH) SERVICE AGREEMENT

OUR SERVICES:

The purpose of this Informed Consent for Technology Assisted Counseling is to inform you, about the process of online counseling services, the counselor and the potential risks and benefits of these services. The purpose is to also help safeguard you, and give you information regarding alternatives to online services. **This consent is an addendum to the face to-face informed consent in the Service Agreement you have already signed during the intake.** If the Individual receiving services is a minor (under age 18) the legal guardian is required to sign. Counseling will take place via audio + video connection only through a specific platform that YFT will direct you to use. Individuals seeking this form of therapy must have access to the necessary technology to do so. Email based communication through the patient portal will not be used for counseling, however it can be used as a support for arranging the logistics of counseling.

CLIENT CONTACT INFORMATION SHEET:

Name: _____ / _____ / _____ / _____
LAST FIRST MIDDLE INITIAL SUFFIX

Social Security #: _____ Primary Email Address: _____
This email will be used for tele-behavioral health services

Gender: FEMALE MALE

Address: _____
STREET

_____ / _____ / _____
CITY STATE ZIP CODE

Date of Birth: _____ / _____ / _____
MONTH DAY YEAR

Telephone Numbers: _____ / _____ / _____
HOME WORK CELL//OTHER

May Youth For tomorrow leave a message on the phone number(s) provided: Yes No
If yes, check all that apply. Home Cell Phone Voice Only Text only Voice and Text

Emergency Contact:

_____ / _____ / _____
NAME RELATIONSHIP HOME PHONE (include area code)

Primary Caregiver:

_____ / _____ / _____
NAME RELATIONSHIP HOME PHONE (include area code)

If the client is a Minor,

Please list a. School attended: _____ b. Grade _____

If the client is an Adult, is there a Legally Authorized Representative or Court Appointed legal guardian? Yes No

If yes, please complete(print):

_____/_____/_____/_____
 NAME RELATIONSHIP CONTACT PHONE FAX # (include area code)

GENERAL OFFICE PRACTICES:

Emergencies

Please note that Youth For Tomorrow Behavioral Health Services is not an emergency service. If you are experiencing a mental health emergency, please call 911 or go directly to the nearest hospital emergency department.

Confidentiality

This means that your name and any information about you will not be discussed with anyone without your and/or your guardian's permission. There are three exceptions to confidentiality that are important for you to understand before you share information with your therapist in session. (1) By law, all suspected abuse and/or neglect of a child or dependent adult must be reported; (2) Action must be taken if it is assessed that the client is a danger to themselves or others; (3) It is possible that client information/records will be released if court ordered. Your therapist is responsible for using a HIPPA compliant platform to provide tele-behavioral health and cannot use any alternative video/audio service to do so.

Policy of Minors in Treatment

All clients under eighteen years of age are considered minors, and parent(s)/legal guardian(s) will sign an informed consent for the treatment of all minors. If at any time the therapist assesses that there is a high risk that the minor may seriously harm him/herself or another person, then the Youth For Tomorrow Behavioral Health Services therapist will notify parents/legal guardians immediately of the concern. Parents/guardians who consent for their minor child to receive tele-behavioral health services, if requested, should make themselves available to speak with the therapist. In cases where parents are divorced but they share custody or there are multiple legal guardians, each parent/guardian must consent to the tele-behavioral health sessions by signing this agreement.

Contact/ Communication with Therapist

You may reach your therapist about general issues, and scheduling sessions by calling your therapist directly. Please be advised that calls received after business hours will be transferred to your therapist's confidential voicemail. Please include your name and number, and your therapist will return your call as soon as possible. In order to protect your confidentiality, your therapist will not use email or text to communicate with you. Please also be advised that our therapists are not available after business hours or during weekends and will not be able to respond to you until the next business day.

Documents Request and fees

There will be a charge for requested documents that require clinical staff completion for outside purposes. There is a ten business day turnaround time for all documents to be completed from time of request submission. Please take into account any documents submitted

prior to a weekend or holiday will require an additional business day. Requests should be submitted to Mikka Sturdivant at (703) 659-9881. All fees for services must be paid in full upon document pickup.

- Less than 10 pages there is no charge
- 11 to 50 pages is \$.50/per page
- 51 and up is \$.25/per page
- Fees include completion and faxing if required

□ **24- Hour Cancellation Policy**

Youth For Tomorrow Behavioral Health Services is committed to providing therapeutic services to the community. When you schedule an appointment with our office, you are asking a professional to hold a specific block of time for you. In order to efficiently serve the community, we have instituted a 24-hour cancellation policy. Any missed appointments, cancelled appointments, or appointment changes within less than 24 business hours will result in a \$50 fee being charged to your account. The fee will not be billed to your insurance company. Failure to comply with these terms may result in referral to an alternate service provide.

Your therapist will need to assess whether or not it is appropriate to provide tele-behavioral health. Your therapist will consider the following:

- If there are any current risks involving possible harm to self or others
- If tele-behavioral health is appropriate to help you to meet your therapeutic goals.
- Serious Mental Illness/Chemically Addicted (MICA) Needing Case Management Services and/or Schizophrenia.
- Have a history of major psychiatric episodes, hospitalizations or drug/alcohol dependence.

Individuals who are seeking to receive tele-behavioral health must meet the following criteria:

- 1) Individuals must be physically located, at the time of the session, in the Commonwealth of Virginia. (Please note that your YFT therapist must be licensed in the Commonwealth/State in which you reside).
- 2) You must provide your therapist with your physical location (address/location) at the beginning of each session in the event that safety issues arise and your therapist needs to ensure your safety. If you do not provide your physical location, tele-behavioral health will not be able to proceed.

□ **Use of Technology and Limits of Communication**

Any communication by unsecured means will only be used for scheduling or for clarifying questions related to the services being provided. If I send any messages involving personal information to my counselor without encryption, I agree to waive my privilege to confidentiality.

- I assume full responsibility for the risks inherent in insecure Internet transmissions, including any losses or damages.
- I agree not to post transcripts or any other recording of my counseling sessions online or to distribute them in any way.
- I commit to not recording in any form (audio or video) of the session.
- I am responsible for providing and maintaining my own electronics to receive tele-behavioral health services.

Tele-Behavioral health Precautions

I understand that Tele-Behavioral Health and face-to-face counseling involve important differences that limit the responsibilities assumed by my counselor. Unlike in face-to-face counseling, my counselor cannot guarantee the same degree of confidentiality since tele counseling partially takes place in a space outside of my counselor's control (i.e., the internet and my physical location). Because tele counseling takes place at a distance and possibly across jurisdictions my counselor cannot reliably intervene in situations that may involve risk to my emotional or physical well-being (e.g., if I am in crisis, suicidal, or require hospitalization). This means I agree to take full responsibility for making the following treatment decisions:

- Whether and where I decide to initiate the tele-behavioral health.
- Whether and how I will protect the confidentiality of my conversation from my side of the Tele-behavioral health sessions.
- Planning in advance what I will do if I become in need of emergency emotional support, including knowing how to contact my local crisis or emergency hot-line.

Court Appearance/Other:

It is the policy of Youth For Tomorrow Behavioral Health Services not to testify in court unless subpoenaed. Fees for court appearances (including preparation and travel time) and court reports will cost \$130.00 per hour and Youth For Tomorrow Behavioral Health Services. Court costs are not generally insurance reimbursable. This policy applies regardless of the party pursuing the subpoena.

Tele-Behavioral Health Counseling and Ensuring Privacy:

In conventional counseling it is the responsibility of the counselor to ensure that no one can over hear the counseling conversation. **During Tele-Behavioral Health sessions** we will ensure that no one will be able to hear on our side of the conversation. Our Therapists counsel from a **private location**. However, we cannot assure the privacy of your location. If you are somewhere where a family member, co-worker or even a stranger might be able to hear or see you then our conversation cannot be kept **confidential**. I strongly encourage you to find a private location to have our conversation. This is important not only for confidentiality, but for the process of counseling. We must be sure that the therapy **time** will not be uninterrupted. **If either party hears an unexpected audible either party may ask, "is it okay to proceed?"**

POLICIES AND FEES:

IF YOU HAVE MEDICAL INSURANCE:

- We will file claims to Medicaid, if applicable, or your private medical insurance company for the services that are provided by our office. In order for the claims to process correctly, please ensure that the information that is provided to our office on the Financial Resources Form is accurate and current. If there is a change in insurance information please let us know immediately. With the exception of Virginia Medicaid, we do not submit requests to secondary insurance companies.

DEDUCTIBLES, CO-PAYMENTS AND COINSURANCE:

- Co-payments are constant and **due at the time the service is rendered**. Coinsurance and deductibles vary for each insurance policy and we can only approximate the percentage covered by each plan. Payment of the estimated portion is due at the time of service. Any uncollected coinsurance and or deductibles will be billed when notification is received of the amount.

PROVIDER COVERAGES:

- Each private insurance company has multiple plans. We may participate with your insurance company, but not your particular plan. Please contact your insurance company to verify that the provider you are seeing is appropriately covered. It is your responsibility to verify coverage for your plan including verifying that your plan will cover tele-behavioral health.
- If the insurance company denies the claim for a plan provision, you will be responsible for the balance.
- If not obtaining services under a Medicaid benefit, private medical insurance coverage is a contract between you and your insurance company. We are not a party to this contract. We will not be involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc. other than to supply factual information as necessary.

You are ultimately responsible for the timely payment for services provided.

IF YOU DO NOT HAVE MEDICAL INSURANCE:

- If you do not have mental health insurance coverage the rates listed below are the out of pocket cost for our various services.
- Out of Pocket Rates:

Counseling Sessions	
Initial Intake Appointment	\$160
Individual Counseling – 30 minutes	\$80
Individual Counseling – 45 minutes	\$95
Individual Counseling – 60 minutes	\$140
Family Counseling without client present	\$90
Family Counseling with client present	\$105

Psychiatric Sessions	
Initial Psychiatric Evaluation	Ranges from \$125-\$175 dependent on severity & time
Medication Management – Moderate to Severe	\$125
Medication Management – Limited	\$85

A reduced cash rate can be requested if you are uninsured. Each therapist has two sliding scale spots and approval is dependent on availability of these slots. If there are reduced rate slots available, your request will be submitted to, and processed by, Youth For Tomorrow's financial department to determine if you qualify for reduction. Proof of income must be submitted before reduced rate will be processed. Reduced rate may vary due to client's circumstance but lowest fee allowed is \$50.

PAYMENT METHODS AND OTHER INFORMATION:

- Fees are to be paid via at the beginning of the sessions to the therapist and will be entered into Advance MD Therapy website's secure payment system prior to the session start time.
- We accept cash, check and Visa, M/C, American Express and Discover.
- Any balance that is left unpaid for over 30 days is subject to a \$10 late fee.** This late fee will be applied to any unpaid account every month until balance is paid in full.
- Accounts that are past due will be turned over to our collection agency and reported to the Credit Bureau.
- Accounts that have statements returned with no forwarding address will be charged \$10 and turned over to our collection agency.
- I acknowledged that I will physical be in the Commonwealth of Virginia during the entire allotted time for my TBH session.**
- There may be times when an invoice will be mailed to your address on file. Payment for an invoice should be mailed to our **Youth For Tomorrow Business Office, 11835 Hazel Circle Drive, Bristow, VA 20136.**
 Questions regarding an invoice for services can be addressed by contacting the Business Office at (703)695-9878.

Note: In situations of divorce, separation, court orders, etc. the party initiating treatment will be financially responsible for the account.

We are committed to providing you with the best possible care and we are willing to discuss our professional fees at any time. Your clear understanding of the Financial Agreement as stated above is important to our relationship. Please ask if you have any questions about our fees, Financial Agreement or your financial responsibility.

By signing this form:

1. I (or my minor child) agree that I reside in the Commonwealth of Virginia. Yes No
2. I (or my minor child) agree to participate in online psychotherapy.
3. I have read, understood and comply with the agreed upon policies.
4. I _____ (**Client or Parent/Legal Guardian**) acknowledge that I have read and agree to the above Service Agreement and Policies & Fees.

Print Name of Patient	Relationship to the Patient	Date
Print Name of Parent/Legal Guardian	Signature of Parent/Legal Guardian I am consenting to my (or my dependents') online treatment.	Date
YFT Staff Signature/ Credentials		Date