Iris Psychological Services
Lisa D. Hensley, Ph.D.
Licensed Psychologist, Texas License #36730

Client Information Form

Personal Information

Full Legal Name: ____

Preferred Name: ____

Date of Birth: ____/____/____ Age: _____ Preferred Pronouns: ___________________

Highest Level of Education Completed: ____
Current Occupation: ____

Demographic Information

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____ Text: ☐ Yes ☐ No

Email: ____

Address: ____

____

____

Emergency Contact Information

Contact Name: ____

Relationship to you: ____

Contact Home Phone: (____) _____-_____ Contact Cell Phone: (____) _____-_____

Primary Care Provider Name: ____

Provider Address: ____

Office Phone: (____) _____-_____

Permission to Consult with Primary Care Provider if necessary: ☐ Yes ☐ No

Medication List

List Any Medications you are currently taking. Please include prescription drugs, over the counter drugs, and recreational drugs. Include dosage, how often you take it, and reason.

Medication: ______________________ Dosage: ___________ How Often: ______________

Reason for Taking: ____

Medication: ______________________ Dosage: ___________ How Often: ______________

Reason for Taking: ____

Medication: ______________________ Dosage: ___________ How Often: ______________

Reason for Taking: ____

Medication: ______________________ Dosage: ___________ How Often: ______________

Reason for Taking: ____

Medication: ______________________ Dosage: ___________ How Often: ______________

Reason for Taking: ____

Previous Psychological History

Have you had previous psychological care or counseling? ☐ Yes ☐ No

If yes, please list the name of the clinician(s), the months you saw them (i.e. Nov ’06 – Nov ’07), and give the nature of the care provided or difficulty at the time:

____

____

____

____

Have you ever been hospitalized for a psychological difficulty? ☐ Yes ☐ No

If yes, please list the place of hospitalization, the dates you were there (i.e. Nov ’06 – Nov ’07), and the nature of the care or difficulty being treated at the time:

____

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____

Current Concerns

In your own words, please share the nature of your concerns you wish to address in therapy with me:

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Any Additional Information or concerns you would like to share:

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Referral Source (Optional)

How did you hear about Iris Psychological Services?

_____ Referred by Another Therapist

_____ Referred by a Friend or Family Member

_____ Google Search

_____ Professional Website

_____ Other: ________________________________

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AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

______________________________ Name of Client   ____________________ Date of Birth

I,____, hereby authorize Dr. Lisa Hensley, Ph.D. (hereinafter "Provider") to disclose/exchange mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to therapist's diagnosis, of the client listed above to:

______________________________ Name   ____________________ Phone

______________________________ Address   ____________________ Fax

______________________________ City   State   Zip

I am requesting this disclosure of information and records for the following purpose:

- ☐ At the request of the individual
- ☐ Other: ____

The specific uses and limitations of the types of health information to be released are as follows:
(Check all that apply)

- ☐ Treatment Coordination
- ☐ Diagnostic Refinement
- ☐ Treatment Planning
- ☐ Other: ____

Such disclosures shall be limited to the following specific types of information:

- ☐ Psychiatric diagnosis(es)
- ☐ Initial Treatment Plan
- ☐ Dates of Treatment
- ☐ Full Treatment Record
- ☐ Treatment Summary
- ☐ Other: ____

This authorization shall remain valid until:________________________________(not to exceed one year)

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has acted in reliance upon it. I also understand that such revocation must be in writing and received by Provider to be effective.

Provider shall not condition treatment upon my signing this authorization and I have the right to refuse to sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Texas law may protect such information.

____   ____________________
Signature of Client   Date

____   ____________________
Signature of Legal Guardian, Relationship to Client   Date

Iris Psychological Services
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Informed Consent and Office Policies
For Adolescent clients

FOR THE PARENT/GUARDIAN:

Parent Authorization for Minor's Mental Health Treatment
To authorize mental health treatment for your adolescent, you must have either sole or joint legal custody of them. If you are separated or divorced from the other parent of your adolescent, please notify me immediately. I will ask you to provide me with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your adolescent.

Potential Benefits and Risks of Psychotherapy
Psychotherapy can have benefits and risks for your adolescent. As with most other forms of treatments, results cannot be guaranteed.

Participation in therapy may result in a number of benefits for your adolescent, including (1) increased insight into patterns of feeling, thinking, behaving and relating to others; (2) resolution or improvement of symptoms that brought the client into therapy; and (3) skills that may help with current and future life challenges. Consistent attendance in therapy, openness on the part of the therapy client, and work both in and outside of therapy sessions are often necessary for improvement.

During the process, your adolescent may experience painful thoughts or emotions (e.g. anger, hurt, frustration, or confusion). Sometimes the insights and skills that the client develops may enhance relationships and other areas of your life. Sometimes those insights and skills may cause changes in relationships or other areas of the client's life that were unanticipated. It is important for the client to talk about reactions to therapy when they come up, so we can decide how to proceed.

How therapy with Dr. Hensley works
The first session/s will involve an evaluation of the client's needs, and a discussion of mutually agreed-upon treatment goals. I will seek your input in developing those goals, but the client's input is also essential to this process. The client and I will work together to reach a shared understanding of where problems come from and what factors contribute to keeping those problems in place. This information guides how the client will move forward in resolving them. Should any of us determine that I as the therapist, the type of treatment offered, or the mode of treatment (online) is not a good fit for the client, I will share recommendations for the right type of treatment and provider. Please feel free to ask any questions about treatment planning, risks and benefits, my expertise, and other potential treatments for the client's condition.

Therapy may also involve recommendations or referrals to additional services that support the client's wellness (e.g. psychiatrist, neuropsychologist, physician). In some cases, these treatments are so vital to the client's recovery that the I am unable to ethically continue providing therapy without your concurrent treatment with these providers because failing to follow these recommendations may result in impaired treatment progress, suicidal thoughts or actions, or deteriorating medical condition. Most often, however, these are recommendations, not requirements.

Individual Parent/Guardian Communications with Me
During your child's treatment, I may meet with the child's parents/guardians either separately or together. Please be aware, however, that my client is your child – not the parents/guardians, nor any siblings or other family members of the child.

If I meet with you or other family members, I will make notes of that meeting in your child's treatment records. Please be aware that those notes will be available to any person or entity that has legal access to your child's treatment record.

Mandatory Disclosures of Treatment Information
In some situations, I am required by law or by the guidelines of my profession to disclose information, even without your or your child's permission. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- Child patients tell me they plan to cause serious harm or death to themselves, and I believe they have the intent and ability to carry out this threat. I must take steps to inform a parent or guardian or others of what the child has told me and how serious I believe this threat to be and to try to prevent the occurrence of such harm.

- Child patients tell me they plan to cause serious harm or death to someone else, and I believe they have the intent and ability to carry out this threat. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm, as well as law enforcement.

- Child patients are doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

- Child patients tell me, or I otherwise learn that it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am [may be] required by law to report the alleged abuse to the appropriate state child-protective agency.

- I am ordered by a court to disclose information.

Disclosure of Minor's Treatment Information to Parents
Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for adolescents to have a "zone of privacy," where they feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy.

It is my policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed to me without your child's agreement. This includes activities and behavior that you would not approve of — or might be upset by — but that do not put your child at risk of serious and immediate harm.

However, if your child's risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether your child is in serious and immediate danger of harm. If I feel that your child is in such danger, I will communicate this information to you.

> ***Example***: If your child tells me that he/she has tried alcohol at a few parties, I **would** keep this information confidential. If you child tells me that he/she is drinking and driving or is a passenger in a car with a driver who is drunk, I **would not** keep this information confidential from you. If your child tells me, or if I believe based on things I learn about your child, that your child is addicted to drugs or alcohol, I **would not** keep that information confidential.

> ***Example***: If your child tells me that he/she is having voluntary, protected sex with a peer, I **would** keep this information confidential. If your child tells me that, on several occasions, the child has engaged in unprotected sex with strangers or in unsafe situations, I **will not** keep this information confidential.

You can always ask me questions about the types of information I would disclose. You can ask in the form of "hypothetical situations," such as: "If a child told you that he or she were doing ________, would you tell the parents?"

Even when we have agreed to keep your child's treatment information confidential from you, I may believe that it is important for you to know about a situation that is going on in your child's life. In these situations, I will encourage your child to tell you, and I will help your child find the best way to do so.

Disclosure of Minor's Treatment Records to Parents
Although Texas state law may give parents the right to see any written records I keep about your child's treatment, by signing this agreement, you are agreeing that your child or teen should have a "zone of privacy" in their meetings with me, and you agree not to request access to your child's written treatment records.

Parent/Guardian Agreement Not to Use Minor's Therapy Information/Records in Custody Litigation
When a family is in conflict, particularly conflict due to parental separation or divorce, it is difficult for everyone, particularly for children. Although my responsibility to your child may require my helping to address conflicts between the child's parents, my role will be strictly limited to providing treatment to your child.

You agree that in any child custody/visitation proceedings, **neither of you will seek to subpoena my records or ask me to testify in court**, whether in person or by affidavit, or to provide letters or documentation expressing my opinion about parental fitness or custody/visitation arrangements.

Please note that **your agreement may not prevent a judge from requiring my testimony**, even though I will not do so unless legally compelled. If I am required to testify, I am ethically bound not to give my opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, I will provide information as needed, if appropriate releases are signed or a court order is provided, but I will not make any recommendation about the final decision(s).

Furthermore, if I am required to appear as a witness or to otherwise perform work related to any legal matter, the party responsible for my participation agrees to reimburse me at the rate of $300 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance, and any other case-related costs.

Location of Services
I am offering services by **teletherapy only for the foreseeable future.** Online therapy allows me to provide services to a broader geographic range of clients than in person services. I am a licensed psychologist in Texas (#36730) and may only provide services to clients within the state of Texas.

Should I decide at a later date to provide in-person psychotherapy services, I will inform you so that you may choose the location of services that meets your needs.

Technology "How To"
Most clients opt in to receive invitations to sessions via email and/or text. You will receive a reminder with a link to log in to the session at our appointment time.

I encourage clients to do a test log in prior to our appointment to make sure that everything is working well on their side. You can check that your mic, speakers, and video are working this way.

It takes a few seconds after you log into the waiting room for us to show up on each other's screens. That is normal. If it seems to be taking an inordinate amount of time, feel free to text, email, or call me so that we can troubleshoot together.

Please be sure to **EXIT** out of any programs that steal bandwidth prior to our sessions. **QUIT** (do not just minimize) skype, carbonite, google drive back up, or any other cloud backup service. Please ensure that no one in your home is streaming video or playing graphic heavy online video games as this will decrease our internet connection.

Tech issues are rare and usually very easy to solve. Turning things off and back on again typically fixes most issues. If technical issues prevent us from continuing with the session via videoconference, we will switch to the telephone for the remainder of that session and attempt to resolve the technical issues for the next session.

Additional Pro-Tips for Online Therapy

- If others will be nearby while you are in therapy, ensure that you have adequate privacy prior to session. Psychotherapy is serious work. You do not want to be interrupted. It is particularly important that your adolescent be allowed the necessary privacy to complete teletherapy sessions without being overheard. Please ensure that your adolescent has access to an area that is private, uninterrupted, and out of earshot of other family members.

- Turn off notifications on your computer and phone once we are connected.

- Bring tissues. If you were in my office, I would provide them for you.

- You may be extra cozy because you are somewhere familiar to you and you may feel more casual because the work is online, and you are used to socializing that way. Remind yourself prior to the session that you are here to do the meaningful work of positive change.

- Research says that the connection between therapist and client is the primary determinant of therapeutic change. I want to make sure that we connect well over video so in our first session, I'll share some tricks to make sure that we can look at each other, rather than the camera, when we talk. If it looks off to you, please let me know. Eye contact matters.

Emergency and Crisis Support
I am not able to provide 24-hour crisis services. I will make every effort to return calls within 24 hours. However, if a life-threatening crisis should occur, contact a crisis hotline, **call 911**, or go to a hospital emergency room. Please contact me after you have taken steps to keep your adolescent safe.

Strengths and Limitations of Online Psychotherapy
Telephone, chat, and video sessions have some advantages over in-person psychotherapy. Many of my clients share with me that it is more convenient (no commute) and more comfortable (in their own space). Some clients share that they feel more able to share “deep” things because it is online rather than in person.

Online therapy is not for everyone. If a client has a poor internet connection, a lack of privacy, or otherwise would simply be more comfortable meeting in person, it is better to connect them with a provider who offers that service. It is important to consider if this applies to you and may impact your therapeutic progress and select an in-person provider if so. In some clinical situations, such as crises or suicidal or homicidal thoughts, in-person treatment may be the most appropriate treatment choice.

Confidentiality and Social Interactions
Should we run into each other socially in person or online, I will never acknowledge working therapeutically with you. To protect the confidentiality of our relationship, I cannot accept invitations to social events or social media requests. While you are welcome to visit my YouTube channel, professional social media pages, or website, I would discourage you from leaving messages there or “following/subscribing” simply to better protect your privacy and anonymity.

Confidentiality Policy in Emergencies
Should you enter a medical or psychological emergency, I need to know the client’s location so that I am able to get help to them. Please share the location from which the client will be conducting our sessions.

Legal Name of Client Receiving Services: ____

Preferred Name of Client Receiving Services: ____

Physical Location of Client Receiving Services:
____
____
____
____
____

Please sign below to indicate that you agree to share the client’s location with me at the beginning of session should it be different from the one listed above.

____
Signature   Date

Confidentiality of Email, Chat, Cell Phone, Video, and Fax Communication
I use secure and encrypted video software for therapy sessions. I use secure email, phone, and faxing systems. However, I want you to be aware that if you do not also use secure/encrypted programs on your side of the communication, the communications may not be secure. As a result, I start at a place of sharing as little as possible via these channels and will adapt to your comfort, with documentation, as we proceed. Security laws state that clients have the freedom to request or "opt in" to less secure means of communication if they are aware of the risks, are comfortable with them, and find it clinically helpful to do so.

I also want to acknowledge that while I regularly check in on the security of our ways of communicating, swift advances in technology preclude my ability to be certain of our security. Just as I cannot guarantee a physical office space will not be broken into, I also cannot guarantee the absolute security of our work online.

Please ensure that you too are doing your utmost to protect your privacy by considering who has access to your email, text messages, and so on before choosing online therapy. For example, I would discourage you from using your work email for our communications. Another way to protect your privacy is to sure to fully exit all online counseling sessions and emails before leaving your computer.

Consultation:
I consult regularly with other professionals regarding my clients to provide the best care possible; however, the client's name or other identifying information is never disclosed. The clients' identity remains completely anonymous and confidentiality is fully maintained.

Rates, Billing, and Payments
We have discussed and agreed upon the following rates:

50-minute Psychotherapy Sessions	$150.00
75-minute Psychotherapy Sessions	$200.00

Fees are due at the time of session unless we have made an agreement to the contrary. Ongoing psychotherapy typically occurs weekly for 50 minutes a session on a time and day agreed upon. Once the appointment is scheduled, you will be expected to pay for it unless you provide at least 24 hours notice.

If you do not keep your account current, I may elect to refer your outstanding balance for collection to an outside collection agent and/or agency. If your account will be referred to an outside collection agency, the cost of that service will be added to your bill.

Other professional fees
The session charge of $150.00 will be used to calculate other professional services you may need and will be broken down into 15 minute increments when services are provided for periods of time outside of those detailed above.

Other professional services include:
- Report or letter writing to physicians, psychiatrists, etc.
- Telephone calls that last greater than 15 minutes
- Extended sessions
- Participation at meetings or phone consultations with other professionals (that you have authorized)
- Record or treatment summary preparation.

If you become involved in legal proceedings that require my assistance, you will be expected to pay for my qualified time, including planning and transportation costs. Due to the complicated nature and difficulty of legal involvement, the fee is $300 per hour. Please take note of your agreement to avoid involving your clinician in legal proceedings (below).

Methods of communication

Given the limitations of security for electronic communication, I would like to know which of the following you are comfortable with. Please sign next to each that you are comfortable using for administrative issues like scheduling, invoicing and collecting paperwork if not submitted through my client portal.

I, _________________________________, consent to allow Dr. Lisa Hensley to contact me in the following ways for administrative purposes:

____Email ____Cell Phone ___Text via Cell Phone ____Voicemail via Cell Phone ____FAX

Please list your preferred email and phone number:

Email : ____

Phone Number : ____

Be aware that basic demographic details like your name, email, and location are considered Protected Health Information (PHI) as is anything clinical in nature like your diagnosis or clinical material. Please initial next to each item you consent to.

I, _________________________________, consent to allow Dr. Lisa Hensley to use unsecured email, cell/VoIP phone text messaging, calls, faxes, or voicemail to transmit to me the following protected health information:

____ Information related to the scheduling of meetings or other appointments

____ Information related to billing and payment

____ Information that is clinical in nature (e.g. treatment summaries, diagnosis)

I, __________________________________, have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

____

Signature Date

We will discuss the options you opted into in our meeting including the clinical utility of communicating in any of the ways mentioned above to decide together if we want to include them in your treatment. Should we decide to share more than basic administrative materials electronically, we need to discuss it first in session so that we can weigh the pros and cons. The delivery of any electronic communication can be intercepted, misdirected, or delayed. Decisions about this should be thoughtful, collaborative, and mutually acceptable.

Discharged from care

Psychotherapy is typically terminated when it becomes reasonably clear that the client no longer needs care. So that you can process the termination of the therapeutic relationship, a final appointment is helpful when ending therapy. This final appointment can be used to review your therapeutic growth, to plan next steps, and to process the termination of therapy.

If you do not show up to your appointment, and/or do not return calls or emails, it will be assumed that you are wanting to discontinue your therapeutic work and you will be discharged from care. In this case, a letter will be sent to you documenting this change.

Litigation Limitation

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.) neither you (client) nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the therapy records be requested.

Mediation and Arbitration

All disputes arising out of or in relation to this agreement to provide psychotherapy services shall first be referred to mediation, before and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of you (the client) and I. The cost of such mediation, if any, shall be split equally, unless otherwise agreed. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorney’s fees. In the case or arbitration, the arbitrator will determine that sum.

Agreement

By signing below, you acknowledge you have read the proceeding information, understand your rights as a client, and agree to psychotherapy services under these conditions. Additionally, your signature below indicates that you understand that I, Lisa Hensley, am an independent practitioner; therefore, the providers I contract with (e.g. my video software, my billing software, etc.) are not responsible for or involved in your care or treatment.

____	________________
Signature of Parent of Minor Client	Date
____	________________
PRINTED Name of Parent of Minor Client	Date

Parent/Guardian of Minor Client:
Please initial after each line and sign below, indicating your agreement to respect your child's privacy:
I will refrain from requesting detailed information about individual therapy sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed. ________ ________

Although I may have the legal right to request written records/session notes since my child is a minor, I agree NOT to request these records to respect the confidentiality of my child's/adolescent's treatment.

________ ________

I understand that I will be informed about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the therapist's professional judgment, unless otherwise noted above. ________ ________

Parent/Guardian Signature ____ Date___________

Parent/Guardian Signature ____ Date___________

For Adolescent clients

FOR THE ADOLESCENT CLIENT:

What is therapy like?
Your parents got a form like this one, only it described the business policies of the office as well as the process of therapy. If you haven't been in therapy before, you may have some questions about how this goes.

During the first session or two, we'll be getting to know each other, and we'll come to a mutual understanding about the difficulties you're having. We'll come up with some goals for treatment and some ideas for how to reach those goals.

It's important to me that you feel like therapy is for you—that we're addressing the problems and concerns that you think are important. I'll ask your parent(s) for input too, but it's important to me that you feel like therapy isn't something that is "done to" you. Rather, it's something that you and I work on together.

Should any of us decide that this isn't a good fit—whether it's me as a therapist, the kind of treatment I offer, or the way I offer treatment (teletherapy, or therapy via videoconference) just let me and/or your parents know, and I'll give you some recommendations for people who might be a better fit. If you have any questions at all—about my experience, about the therapy we're doing—I hope that you'll ask.

Therapy has the potential for both risks and benefits. Participation in therapy may result in a number of benefits, including (1) increased insight into patterns of feeling, thinking, behaving and relating to others; (2) resolution or improvement of symptoms that brought you into therapy; and (3) skills that may help with you current and future life challenges. Consistent attendance in therapy, openness on your part, and doing the work both in and outside of therapy sessions are often necessary for improvement.

Therapy does carry some risk. We may talk about things that are embarrassing or painful. During the process, you may experience painful thoughts or emotions (e.g. anger, hurt, frustration, or confusion). The idea isn't to leave you "stuck" in that painful place, but to help you work through it. Sometimes the insights and skills that you develop may enhance relationships and other areas of your life. Sometimes those insights and skills may cause changes in relationships or other areas of your life that were unanticipated. It is important for you to talk about reactions to therapy when they come up, so we can decide how to proceed. I may also recommend to your parent/guardian that you see an additional professional, such as a psychiatrist, as part of your treatment.

Communicating with Your Parents
During your treatment, I may meet with your parents, either separately or with you. I may ask for information from them about how you are doing, or I may want to give them a general progress update on your treatment. In general, I will talk with you about the purpose of those meetings, and go over what, if any, information I intend to share. This may not be possible in certain circumstances, which are outlined below.

In some situations, I am required by law or by the guidelines of my profession to disclose information to your parents and/or to outside parties when necessary. I have listed some of these situations below.

Confidentiality cannot be maintained when:

- You tell me that you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat. I must take steps to inform a parent or guardian or others of what you have told me and how serious I believe this threat to be, and to try to prevent the occurrence of such harm.

- You tell me that you plan to cause serious harm or death to someone else, and I believe you have the intent and ability to carry out this threat. In this situation, I must inform a parent or guardian or others, and I may be required to inform the person who is the target of the threatened harm, as well as law enforcement.

- You are doing things that could cause serious harm to them or someone else, even if you are not intending to harm yourself or someone else. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

- I suspect that a child is being neglected or abused--physically, sexually, or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, I am required by law to report the alleged abuse to the appropriate state child-protective agency.

- I am ordered by a court to disclose information.

Therapy is most effective when a trusting relationship exists between the psychologist and the patient. Privacy is especially important in earning and keeping that trust. As a result, I believe it is important for you to have a "zone of privacy" in therapy, where you feel free to discuss personal matters without fear that your thoughts and feelings will be immediately communicated to your parents.

I have asked your parent/guardian(s) to agree that I will provide general information about your progress in treatment, but that I will not share specific information with them without your consent, except for the times that confidentiality cannot be maintained, which are described above.

Even when we have agreed to keep your treatment information confidential, I may believe that it is important for your parents to know about a situation that is going on in your life. In these situations, I will encourage you to talk with your parents, and will help you find the best way to do so. I may meet with you and your parents together so that I can assist you.

I've also asked your parents to agree to keep my written records of your treatment confidential between you and me. However, be aware that Texas state law may give your parents the right to see those records if they do request access to them.

Location of Services
I am offering services by **teletherapy only for the foreseeable future.** Online therapy allows me to provide services to a broader geographic range of clients than in person services. I am a licensed psychologist in Texas (#36730) and may only provide services to clients within the state of Texas.

Telephone, chat, and video sessions have some advantages over in-person psychotherapy. Many of my clients share with me that it is more convenient (no commute) and more comfortable (in their own space). Some clients share that they feel more able to share "deep" things because it is online rather than in person.

Online therapy is not for everyone. If you have a poor internet connection, a lack of privacy, or otherwise would simply be more comfortable meeting in person, it is better to connect you with a provider who offers that service. It is important to consider if this applies to you and may impact your therapeutic progress and select an in-person provider if so. In some clinical situations, such as crises or suicidal or homicidal thoughts, in-person treatment may be the most appropriate treatment choice.

Technology "How To"

Most clients opt in to receive invitations to sessions via email and/or text. You will receive a reminder with a link to log in to the session at our appointment time.

I encourage clients to do a test log in prior to our appointment to make sure that everything is working well on their side. You can check that your mic, speakers, and video are working this way.

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Tech issues are rare and usually very easy to solve. Turning things off and back on again typically fixes most issues. If technical issues prevent us from continuing with the session via videoconference, we will switch to the telephone for the remainder of that session and attempt to resolve the technical issues for the next session.

Additional Pro-Tips for Online Therapy

- If others will be nearby while you are in therapy, ensure that you have adequate privacy prior to session. Psychotherapy is serious work. If you have concerns about privacy or being overheard, please let me know right away so we can problem-solve about how to handle the issue.

- Turn off notifications on your computer and phone once we are connected.

- Bring tissues. If you were in my office, I'd provide them for you.

- You may be extra cozy because you are somewhere familiar to you and you may feel more casual because the work is online, and you are used to socializing that way. Remind yourself prior to the session that you are here to do the meaningful work of positive change.

- Research says that the connection between therapist and client is the primary determinant of therapeutic change. I want to make sure that we connect well over video so in our first session, I'll share some tricks to make sure that we can look at each other, rather than the camera, when we talk. If it looks off to you, please let me know. Eye contact matters.

Iris Psychological Services
Lisa D. Hensley, Ph.D.
Licensed psychologist, Texas License #36730

Emergency and Crisis Support
Please note that I am not able to provide 24-hour crisis services. I will make every effort to return calls within 24 hours. However, if a life-threatening crisis should occur, please tell your parent/guardian(s) so that they can help keep you safe. You may also contact a crisis hotline, call 911, or go to a hospital emergency room. Please don't wait to hear back from me to do these things. Please contact me AFTER you have taken these steps to keep yourself safe.

Confidentiality and Social Interactions
Should we run into each other socially in person or online, I will never acknowledge working therapeutically with you. To protect the confidentiality of our relationship, I cannot accept invitations to social events or social media requests. While you are welcome to visit my YouTube channel, professional social media pages, or website, I would discourage you from leaving messages there or "following/subscribing" simply to better protect your privacy and anonymity.

Confidentiality Policy in Emergencies
Should you have a medical or psychological emergency, I need to know your location so that I am able to get help to you. Please share the location from which you will be conducting our sessions.

Legal Name of Client Receiving Services: ____

Preferred Name of Client Receiving Services: ____

Physical Location of Client Receiving Services:
____
____
____
____
____

Please sign below to indicate that you agree to share the client's location with me at the beginning of session should it be different from the one listed above.

____
Signature   Date

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Confidentiality of Email, Chat, Cell Phone, Video, and Fax Communication
Please be careful of your privacy when using electronic communication. I use secure and encrypted video software for therapy sessions. Be aware that I can't guarantee the security of information you share through email or text. Those are not secure ways of getting in touch with me, so I communicate using those methods only with your parents' permission, and only for things like scheduling or cancelling appointments.

Please ensure that you too are doing your utmost to protect your privacy by considering who has access to your email, text messages, and so on before choosing online therapy. Be sure to exit all online counseling sessions and emails before leaving your computer.

Consultation:
I consult regularly with other professionals regarding my clients to provide the best care possible; however, your name or other identifying information is never disclosed. Your identity remains completely anonymous and confidentiality is fully maintained.

Discharged from care
Psychotherapy is typically ended when it becomes reasonably clear to both of us that you have met your therapeutic goals. Depending on your needs, we may schedule "follow-up" sessions, or we may just have a "wrap-up" therapy session so we can process any feelings or concerns you have about ending therapy.

Sometimes other circumstances cause therapy to end, such as a move. In those cases, I will make every effort to help you get connected with appropriate services for your needs.

Agreement
By signing below, you acknowledge you have read this information, understand your rights as a client, and agree to be an active participant in your own treatment.

____ ________________
Client Signature Date

____ ________________
Client PRINTED name Date

Iris Psychological Services
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NOTICE OF PRIVACY PRACTICES
Effective October 1, 2020

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

For more information about this notice, please contact Dr. Lisa Hensley, PH.D. at
drhensley@irispsychologicalservices.com or (682) 438 -5195

This Notice of Privacy Practices describes how I may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice of Privacy Practices is **NOT** an authorization.

It also describes your rights to access and control your protected health information. "Protected health information" or "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health, or related mental health care services.

I am required to abide by the terms of this Notice of Privacy Practices. Upon your request, I will provide you with any revised Notice of Privacy Practices. Copies of this Notice are available from me by utilizing the contact information listed above.

I. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you which I have created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of the health care. I must provide you with this Notice about my privacy practices and such a notice must explain how, when, and why I will "use" and "disclose" your PHI.

A "use" of PHI occurs when I share, examine, give, or otherwise divulge to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. I am legally required to follow the privacy practices described in this Notice; however, I reserve the right to change the terms of the Notice and my privacy policies at any time in accordance with HIPAA compliance and laws. Any changes will apply to PHI on file with me already.

II. HOW I MAY USE AND DISCLOSE YOUR PHI

I will use and disclose your PHI for many different reasons. I will need your prior written authorization for some of these uses or disclosures; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. **Uses and Disclosures Relating to Treatment, Payment or Health Care Operations Do Not Require Your Prior Written Consent**. I can use and disclose your PHI without your consent ONLY for the following reasons:

i. **For Treatment**. I can use your PHI within my practice to provide you with mental health treatment including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your case. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

ii. **To Obtain Payment for Treatment**. I can use your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

iii. **For Health Care Operations**. I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who have provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

iv. **For Patient Incapacitation or Emergency**. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent is not required if you need emergency treatment as long as I try to get your consent after treatment is rendered; or, if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. **Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization.** I can use and disclose your PHI without your consent or authorization for the following reasons:

i. **When federal, state, or local laws require disclosure**. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to governmental agencies and law enforcement personnel about victims of abuse or neglect.

ii. **When judicial or administrative proceedings require disclosure**. For example, I may have to use or disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or claim for workers' compensation benefits. I may also have to use or disclose your PHI in response to a subpoena.

iii. **When law enforcement requires disclosure**. For example, I may have to use or disclose your PHI in response to a search warrant.

iv. **When public health activities require disclosure**. For example, I may have to use or disclose your PHI to report to a governmental official an adverse reaction that you may have to a medication.

v. **When health oversight activities require disclosure**. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.

vi. **To avert a serious threat to health or safety**. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. Any such disclosures will only be made to someone able to prevent the threatening harm from occurring.

vii. **For specialized government functions**. For example, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations, if you are in the military.

viii. **To remind you about appointments and to inform you of health-related benefits or services**. For example, I may have to use or disclose your PHI to remind you about your appointments or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

C. **Certain Uses and Disclosures Require You to Have the Opportunity to Object**. Disclosures to family, friends, or others: I may provide your PHI to a family member, friend, or other person that you indicate that is involved in your care or the payment for your health care unless you object in whole or in part. The opportunity to consent may be obtained retroactively in an emergency.

D. **Other Uses and Disclosures Require Your Prior Written Authorization**. In any situation not described in sections III A, B, and C, above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I have not taken any action in reliance on such authorization) of your PHI by me.

III. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. **The Right to Request Restrictions on My Uses and Disclosures**. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members, friends, or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests but am not legally required to accept them. If I do accept your requests, I will put them in writing and will abide by them except in emergency situations. Be advised that you may not limit the uses and disclosures that I am legally required to make.

B. **The Right to Choose How I Send PHI to You.** You have the right to request that I send confidential information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. **The Right to Inspect and Receive a Copy of Your PHI.** In most cases, you have the right to inspect and receive a copy of the PHI that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I do not have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

D. **The Right to Receive a List of the Disclosures I Have Made.** You have the right to receive an Accounting of Disclosure listing the instances in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use; disclosures permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; and, disclosures made before April 14, 2003. I will respond to your request for an Accounting of Disclosure within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I may charge you a reasonable, cost-based fee for each additional request.

E. **The Right to Amend Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide, in writing, the request and your reason for the request. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request to amend your PHI, I will make the changes, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. **The Right to Receive a Paper Copy of This Notice.** You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

IV. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I have made about access to your PHI, you may file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S. W., Washington D. C. 20201. I will not take retaliatory action against you if you file a complaint about my privacy practices.

V. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES: Dr. Lisa Hensley, Ph.D . at drhensley@irispsychologicalservices.com or (682) 438 -5195

ACKNOWLEDGEMENT OF RECEIPT: NOTICE OF PRIVACY PRACTICES

I, ________________________, understand that by signing below I have read and understand Iris Psychological Services Notice of Privacy Practices as outlined above. I understand I have the right to ask questioned about this notice and to request a copy of the notice at any time. I also acknowledge, I have the right to refuse to sign this acknowledgement and for that refusal to be documented as part of my file.

____ ______________

PRINT Legal Name of Client Date

____ ______________

Signature of Client Date

____ ______________

Signature of Legal Guardian if Client is an Adolescent Date