



*Client Intake*

Today's date \_\_\_\_\_

Name (both if couple) \_\_\_\_\_ Date(s) of Birth \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Which number is the best to reach you? \_\_\_\_\_

Email Address (thereby giving your permission to be contacted by us via email):  
\_\_\_\_\_

How did you hear about our services? *(if you found us online, please be as specific as possible! We track for marketing purposes):*  
\_\_\_\_\_

Occupation (self, spouse, parents): \_\_\_\_\_ Work location: \_\_\_\_\_  
(city, state)

Names and birthdates of any children: \_\_\_\_\_

If relevant, who has legal custody? \_\_\_\_\_

Whom can we call in case of emergency? \_\_\_\_\_  
Name Phone Relationship

Are you currently being treated by a physician? If so, for what?  
\_\_\_\_\_

Physician Name/Contact Number (we will not contact your doctor without your written permission):  
\_\_\_\_\_

Current medications, if any: \_\_\_\_\_

Please list past or present therapists, and dates of service: \_\_\_\_\_

How do you hope therapy will help you? \_\_\_\_\_

As you see it, what is bothering you most right now? \_\_\_\_\_

What led you to seek help at this time? \_\_\_\_\_

How would you like to change things? \_\_\_\_\_



### *Informed Consent, Policies and Procedures*

As Licensed Marriage and Family Therapists, we are specially and expertly trained to work with couples and families, as well as individuals. We approach therapy from a systemic perspective, understanding people in the context of their relationship systems. We believe each person in a relationship is important to the system as a whole. Relationships become out of balance as a result of many different factors and patterns, which can be examined in the therapy sessions. We also view the systems within individuals: how their thoughts, feelings, and experiences affect their situation. We work with clients to understand how all these factors contribute to their present circumstances.

During an initial getting-to-know-you period, your therapist will work with you to develop an initial understanding of your problem/situation. We will then begin work to define your goals. Depending on the nature of your goals in therapy and the amount of consistent effort that is applied, therapy may involve just a few sessions or several months or years. Your goals may change as time goes on. Our therapists have various tools they use in therapy to customize to the uniqueness of the people we see. Some of these tools include cognitive-behavioral techniques, experiential exercises, homework assignments, and family-of-origin work.

We want to work cooperatively with you at all times, and we are always open to your questions and feedback. You and your therapist share responsibility for the outcome of therapy.

#### *The possible benefits of participating in therapy may include:*

- A better ability to handle or cope with marital, family, and other interpersonal issues.
- Increased understanding of family and personal goals and values.
- A deepening of connections in your relationships.
- A healing of wounds inflicted past or present.
- Greater happiness as an individual and increased relational harmony.
- Resolution of specific concerns brought to therapy.

#### *The possible risks of treatment may include:*

- No guarantee as to therapy outcome. Some people experience no improvement in their situation – a few may even think things are worse after treatment.
- The experiencing of intense and uncomfortable feelings as unpleasant events, relationship patterns, and other concerns are addressed.
- Therapy can sometimes lead to individual decisions that can be disruptive for you or your family.
- Some health insurance companies will not cover the cost of family or couple therapy.

**Outside consultation:** At times it will be important for the progress of therapy to contact other professionals who are helping you or your family. Such professionals may be schoolteachers, psychiatrists, therapists or attorneys. Your therapist will not make such contact without the written permission of all participating family members. As a means to help clients as effectively as possible, we regularly consult with other experienced therapists regarding client issues. We do not reveal any identifying information about our clients. In certain situations, your therapist may suggest an outside psychiatric consultation. You are not mandated to follow this recommendation; however, if the therapist deems such a consultation necessary, he or she may make it a condition for continued therapy.

**Fees:** The rate for a 50-minute session with Laurel Fay and Haley Axton is \$180, and for other associates the rate is \$150. Payment in full is expected at the time of service. If longer sessions occur, the fee will be prorated. Fees for additional time or services, including travel time, will be billed at the regular session fee rate. Such additional services may include, but are not limited to, consultation with other professionals, preparation of reports or correspondence, any necessary court appearances, school meetings, phone calls

lasting over 10 minutes. We accept cash, personal checks, Visa or MasterCard. If you chose to pay with a credit card, you will be billed using our secure online system. This means that after your credit card information is collected once, charges will be billed to that card automatically. You may change your payment method at any time. We do not bill insurance companies directly, but we can give you a statement of services for you to submit to your insurance company.

**Cancellation policy:** THE USUAL PER SESSION RATE IS CHARGED FOR MISSED APPOINTMENTS OR FOR CANCELLATIONS MADE WITH LESS THAN 24 HOURS NOTICE GIVEN. Your time has been reserved for you and since this is the basis of our livelihood, only with sufficient notice can we make that time available to someone else. If you do need to cancel an appointment, **please call or text rather than email** we receive your call or text much faster than we do your email message.

**Phone Numbers:** The main number to call is 301-563-9520. Your therapist will return calls in a timely manner, between 9 a.m. and 5 p.m. Monday-Friday, and will return weekend calls on Monday, unless Monday is a holiday.

**Legal Proceedings:** To contain our costs and remain focused on our primary mission to help our clients improve their quality of life, it is our longstanding policy and practice not to complete character references or offer court testimony. To clarify, we will write a case summary of a client's attendance and progress in therapy for him or her to take to court. However, we will not appear voluntarily for a legal proceeding. Despite being informed of our practice's policy, if our staff is subpoenaed for a legal proceeding, the cost of such services is \$500/hour per person subpoenaed.

**Emergencies:** Our aim is to be available to you should an emotional emergency arise. Therapeutic calls are billed pro-rated at the regular fee. However, we cannot provide 24-hour availability. If you are in need of immediate attention, please call the 24-hour hotline at (240) 777-4000 at the Montgomery County Crisis Center, the Maryland State Crisis Hotline at 1-800-422-0009, or go immediately to your nearest hospital emergency room.

**Termination:** Client, therapist, or both can decide to terminate therapy for a variety of reasons. If it is the therapist's therapeutic judgement that therapy be terminated, referrals for other treatment options will be provided. When it is time to stop therapy, it is important that there be time given before terminating to bring closure to the therapeutic relationship by talking about what has and has not taken place during the time together and to say "good-bye." This is usually done with a minimum of one session devoted to reviewing our therapeutic work together, and your future goals.

I understand that Laurel A. Fay, M.S., Licensed Clinical Marriage and Family Therapist or one of her associates will provide professional services to:

Client name(s): \_\_\_\_\_.

My signature below affirms my informed and voluntary consent to enter therapy (and/or have my child/ren enter therapy). I affirm that prior to becoming a client of Laurel Fay and Associates, I was given sufficient information to understand the nature of therapy, including the possible risks and benefits, and also the nature of confidentiality. I understand the office policies and procedures and cancellation policy and agree to uphold these policies. I have had an opportunity to ask questions and have had my questions answered satisfactorily. I understand that I can ask questions and raise concerns about the treatment at any time.

\_\_\_\_\_  
Name Signature Date

\_\_\_\_\_  
Name Signature Date

\_\_\_\_\_  
Name Signature Date



### *Confidentiality*

At Laurel Fay and Associates, our therapists strive to provide a safe haven in which you can openly explore very personal issues. We are committed to guarding your right to privacy, within the limits of the law, and because of the limits of the law there are issues surrounding confidentiality of which you should be aware.

1. There are certain situations in which a **therapist is required by law to reveal information** obtained during therapy. In these situations, confidentiality may be rescinded and information disclosed for the protection and safety of all parties involved; this includes calling emergency services. Disclosure is required by law in the following circumstances:
  - a. A reasonable **suspicion of abuse/neglect of a child or vulnerable adult**. A report will be made to appropriate protective agencies.
  - b. When you **threaten grave bodily harm to others**. Your therapist has a duty to warn those you have threatened.
  - c. When you are **suicidal or threaten significant bodily harm to yourself**. Your therapist has a duty to obtain help from others such as family members or other professionals to do what is necessary to keep you safe.
  - d. When a court of law issues a legitimate **court order** (signed by a judge).
  - e. When you are in a **probation or parole period** or other legal situation that would require disclosure.
2. Except in the above circumstances, your therapist will release information about you only if you provide a **written request**. Releases of information for families/couples in therapy require the written permission of **every member** of the family/couple in treatment able to execute a waiver.
3. If your therapist sees a **child in your family under the age of consent** (younger than 16), all custodial parents have a right to information shared in the session. Custodial parents should be aware that exercising this right may be detrimental to the therapeutic process, and so may wish to allow confidentiality between the child and therapist.
4. There are special **confidentiality concerns for families and couples** in treatment:
  - a. The couple or family is viewed as the “treatment unit.”
  - b. Your therapist will not reveal any individual’s confidences to others in the treatment unit.
  - c. “Secrets” that are kept from family members are generally not healthy for you or your family. For this reason, if an individual member or subset of the couple/family discloses a confidence that has bearing on other family members, your therapist will encourage the person(s) to reveal the information to the other members. Your therapist will support you in finding ways to make such a disclosure.
  - d. Should you reveal a “secret” that you refuse to disclose to the others and that puts your therapist, by knowing the “secret”, in a position of hurting their honest relationship with others in the treatment unit, your therapist will terminate the therapy and give you outside referrals for continued treatment.

**I affirm that I have read and agree to the nature of confidentiality in therapy as set forth above.  
I have had an opportunity to ask questions and have had my questions answered satisfactorily.**

_____	_____	_____
Name	Signature	Date
_____	_____	_____
Name	Signature	Date



## *Electronic Communication Policy*

Email and texting offers an easy and convenient way for therapist and client to communicate, but can also introduce unique challenges into the therapist-client relationship. At Laurel Fay & Associates (LFA), we are dedicated to protecting your privacy and confidentiality. Below are some guidelines for contacting your LFA therapist using email or text.

- We prefer only to use email to arrange or modify appointments. Please do not email content related to your therapy sessions, as email is not completely secure or confidential.
- For emergencies, please go to an emergency room. Do not use email for emergencies.
- Email is not a substitute for seeing your therapist. If you think you might need to be seen, please call and schedule an appointment.
- Emails should **not** be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- **Email is not confidential.** Be aware that if you send emails from work, your employer has a legal right to read your email.
- Email is part of your legal record; a copy will be printed and put in your file.
- Either you or your therapist can revoke permission to use email at any time. Further, texting also introduces some of the same challenges.
- Like email, it is not a substitute for seeing your therapist or making an appointment.
- Texting may be used to request that your therapist give you a call.
- Because phones are lost or stolen, it is imperative that you do not communicate information of a sensitive nature over a text.

Please initial below:

\_\_\_\_\_ I have read the above information and understand the limitations of electronic communication. I understand that my therapist at LFA may not be able to communicate with me electronically about my specific issue if there are concerns regarding confidentiality. I also understand that if I choose to communicate personal therapy-related content via email or text, I alone assume all potential risks regarding confidentiality.

Please mark your choice regarding how we handle electronic communications with you:

- \_\_\_\_\_ It is permissible for my therapist at LFA to contact me via email regarding scheduling.  
\_\_\_\_\_ It is permissible for my therapist at LFA to contact me via text regarding scheduling.  
\_\_\_\_\_ It is not permissible for my therapist at LFA to contact me via email.  
\_\_\_\_\_ It is not permissible for my therapist at LFA to contact me via text.

Client names: \_\_\_\_\_

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
Date

Rev. 3/2017



### Informed Consent Form: Teletherapy

I \_\_\_\_\_ (client) hereby consent to engage in teletherapy with \_\_\_\_\_ (Clinician). I understand that

“teletherapy” includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental information, both orally and visually.

*I understand that I have the following rights with respect to teletherapy:*

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. Unless explicitly agreed otherwise, the teletherapy exchange is confidential. Any personal information I choose to share will be held in the strictest confidence. The laws that protect the confidentiality of my medical information also apply to teletherapy. Just as with face-to-face clients, the clinician will not release your information to anyone without your prior approval, or required to do so by law. In Texas mental health providers are required to notify authorities if they become convinced a client is about to physically harm someone; or if they are abusing, or about to abuse, children, the elderly, or the disabled.
3. You understand that this teletherapy occurs in the state of Maryland, (USA), and is governed by the laws of that state.
4. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the clinician, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
5. In addition, I understand that teletherapy based services and care may not be as complete as face- to-face services. I also understand that if the clinician believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychologist, my condition may not be improve, and in some cases may even get worse
6. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.
7. I accept that teletherapy does not provide emergency services. During our first session, the clinician and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.
8. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session, (4) if I decide to keep copies of emails or communication on my computer, it is up to me to keep that information secure.
9. I understand that while email may be used to communicate with the clinician, confidentiality of emails cannot be guaranteed.
10. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

**I have read, understand and agree to the information provided above.**

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**Client (or Guardian's) Signature**

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**Date**

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**Print Name**



**Electronic Payment Authorization**

Please indicate the card you wish to use for all services rendered through this practice. Charges for services rendered will be deducted from the card designated below at the time of service.

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Home Number: \_\_\_\_\_ Mobile Number: \_\_\_\_\_

Email: \_\_\_\_\_

If different from client information above, please indicate the billing information associated with the credit/debit card you wish to use:

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Email: \_\_\_\_\_

I authorize all service fees to be deducted from the card ending in \_\_\_\_\_ (last four digits of the card). Please enter the CVV code \_\_\_\_\_ (three digit code on back of the card).

I authorize the use of this card for all services and fees at the time they are rendered for the following parties:

Full Name(s) \_\_\_\_\_

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. \*By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

\_\_\_\_\_  
Cardholder Signature Date

-----  
Card (circle one):          Visa                  MasterCard                  Discover                  AMEX

Card Number: \_\_\_\_\_ CVV code \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Revised 3/2020



## *Why We Don't Accept Insurance For Our Services*

We too have health insurance plans that we use for some of our medical needs. However, we don't accept insurance in our practice for several reasons. We want you to understand why so that you can make an informed choice about whether or not it is best for you to use your insurance to pay for your therapy.

*Using your insurance means:*

1. Your therapist would have to give you a Mental Disorder Diagnosis (like Major Depressive Disorder or Obsessive/ Compulsive Disorder for example).
2. Every few weeks, your therapist would have to write a report that shows what progress, if any, you are making in regard to that mental disorder.
3. Then, someone at the insurance company (who does not know you nor your therapist) will decide if they will continue to pay for us to work together. It is as if they are listening in on your therapy sessions.
4. The exact number is unclear, but we have been told that up to 14 different people look at that report with your Mental Disorder Diagnosis before making a payment on the account.
5. All of this information becomes a part of your health record. This compromises your privacy, and if you are employed by or work for a government agency, may potentially jeopardize any security clearances you possess. In our practice, your files are locked away and no one is able to see them except your therapist unless, at some point, you request that your therapist share them with someone else (e.g. your physician etc.).

*Make an informed decision:*

Above are some of the reasons we do not accept insurance as payment for services. If you want to keep your issues private and the paper trail to a minimum, using your insurance will not afford you the level of privacy you desire. Knowing what is required of you and your therapist when using your insurance plan to pay for sessions is the only way to make an informed decision. Call your insurance company if you have further questions.

You may be concerned about therapy becoming very expensive if you pay on your own. However, generally people experience significant improvement fairly quickly within 8-20 sessions.

If using your insurance is the right decision for you, they can provide you with a list of providers in your area that accept your plan. Simply call the number for mental health services on the back of the card for this list of providers. While we do not bill insurance companies directly, at your request we can provide a statement of services for you to submit to your insurance company. In addition, we are willing to work with you to fill out needed insurance forms. As an additional service to you, with your permission we can call your insurance company and inquire as to your out-of-network provider benefits. Remember that there is a possibility that your insurance company will refuse to speak with anyone but you about your benefits or the specifics of your plan. If you'd like to try this option, please let your therapist know.



*Our commitment is to provide quality mental health and substance abuse services to all individuals without regard to race, color, religion, national origin, gender, age, sexual orientation, or disabilities.*

### *Right to Know Benefits*

Individuals have the right to be provided information from the purchasing entity (such as employer or union or public purchaser) and the insurance/third party payer describing the nature and extent of their mental health and substance abuse treatment benefits. This information should include details on procedures to obtain access to services, on utilization management procedures, and on appeal rights. The information should be presented clearly in writing with language that the individual can understand.

### *Professional Expertise*

Individuals have the right to receive full information from the potential treating professional about that professional's knowledge, skills, preparation, experience, and credentials. Individuals have the right to be informed about the options available for treatment interventions and the effectiveness of the recommended treatment.

### *Contractual Limitations*

Individuals have the right to be informed by the treating professional of any arrangements, restrictions, and/or covenants established between third party payer and the treating professional that could interfere with or influence treatment recommendations. Individuals have the right to be informed of the nature of information that may be disclosed for the purposes of paying benefits.

### *Appeals and Grievances*

Individuals have the right to receive information about the methods they can use to submit complaints or grievances regarding provision of care by the treating professional to that profession's regulatory board and to the professional association. Individuals have the right to be provided information about the procedures they can use to appeal benefit utilization decisions to the third party payer systems, to the employer or purchasing entity, and to external regulatory entities.

### *Confidentiality*

Individuals have the right to be guaranteed the protection of the confidentiality of their relationship with their mental health and substance abuse professional, except when laws or ethics dictate otherwise. Any disclosure to another party will be time limited and made with the full written, informed consent of the individuals. Individuals shall not be required to disclose confidential, privileged or other information other than: diagnosis, prognosis, type of treatment, time and length of treatment, and cost.

Entities receiving information for the purposes of benefits determination, public agencies receiving information for health care planning, or any other organization with legitimate right to information will maintain clinical information in confidence with the same rigor and be subject to the same penalties for violation as is the direct provider of care.

Information technology will be used for transmission, storage, or data management only with methodologies that remove individual identifying information and assure the protection of the individual's privacy. Information should not be transferred, sold or otherwise utilized.

### *Choice*

Individuals have the right to choose any duly licensed/certified professional for mental health and substance abuse services. Individuals have the right to receive full information regarding the education and training of professionals, treatment options (including risks and benefits), and cost implications to make an informed choice regarding the selection of care deemed appropriate by individual and professional.

### *Determination of Treatment*

Recommendations regarding mental health and substance abuse treatment shall be made only by a duly licensed/certified professional in conjunction with the individual and his or her family as appropriate. Treatment decisions should not be made by third party payers. The individual has the right to make final decisions regarding treatment.

### *Parity*

Individuals have the right to receive benefits for mental health and substance abuse treatment on the same basis as they do for any other illnesses, with the same provisions, co-payments, lifetime benefits, and catastrophic coverage in both insurance and self-funded/self-insured health plans.

### *Discrimination*

Individuals who use mental health and substance abuse benefits shall not be penalized when seeking other health insurance or disability, life or any other insurance benefit.

### *Benefit Usage*

The individual is entitled to the entire scope of the benefits within the benefit plan that will address his or her clinical needs.

### *Benefit Design*

Whenever both federal and state law and/or regulations are applicable, the professional and all payers shall use whichever affords the individual the greatest level of protection and access.

### *Treatment Review*

To assure that treatment review processes are fair and valid, individuals have the right to be guaranteed that any review of their mental health and substance abuse treatment shall involve a professional having the training, credentials and licensure required to provide the treatment in the jurisdiction in which it will be provided. The reviewer should have no financial interest in the decision and is subject to the section on confidentiality.

### *Accountability*

Treating professionals may be held accountable and liable to individuals for any injury caused by gross incompetence or negligence on the part of the professional. The treating professional has the obligation to advocate for and document necessity of care and to advise the individual of options if payment authorization is denied.

Payers and other third parties may be held accountable and liable to individuals for any injury caused by gross incompetence or negligence or by their clinically unjustified decisions.

### *Participating Groups:*

- American Association for Marriage and Family Therapy (membership: 25,000)
- American Counseling Association (membership: 56,000)
- American Family Therapy Academy (membership: 1,000)
- American Nurses Association (membership: 180,000)
- American Psychological Association (membership: 142,000)
- American Psychiatric Association (membership: 42,000)
- American Psychiatric Nurses Association (membership: 3,000)
- National Association of Social Workers (membership: 155,000)
- National Federation of Societies for Clinical Social Work (membership: 11,000)

### *Supporting Groups:*

- National Mental Health Association
- American Group Psychotherapy Association
- American Psychoanalytic Association
- National Association of Alcoholism and Drug Abuse Counselors



## *Our Social Media Policy*

This document outlines our office policies related to the use of social media. Please read it to understand how our therapists conduct themselves on the Internet as mental health professionals, and how you as a client can expect your therapist to respond to various interactions that may occur between you both on the Internet. If you have any questions about anything within this policy, we encourage you to discuss those questions or concerns with your therapist. As new technology develops and the Internet changes, there may be times when we will need to update this policy. If we do so, your therapist will notify you of any policy changes and make sure a copy of the updated policy is available to you.

### *Friending*

Laurel Fay and Associates has a professional profile and a fan page on Facebook. Your therapist may also maintain a personal Facebook profile; the policy of the practice is that it is up to each therapist to decide if they include clients as “friends” or not. If you have questions about this, please bring them with your therapist; they welcome your input. We maintain a Facebook page to allow people to share blog posts and practice updates with other Facebook users. All of the information shared on our page is also available on our website, [www.laurelfay.com](http://www.laurelfay.com). You are welcome to view our Facebook page and read or share articles posted there. Note that you should be able to subscribe to the page via RSS without becoming a Fan and without creating a visible, public link to our Page if that is of concern to you.

### *Following*

Laurel Fay publishes a blog on our website and Facebook that includes posts from all our associates. In addition, LFA has a presence on Twitter, Instagram and Pinterest. We have no expectation that you as a client will follow us on any platforms, though of course we would be delighted if you did so. However, if you use an easily recognizable name on a social media site and connect with us there, you and your therapist may briefly discuss it if it has a potential impact on your working relationship. Our primary concern at LFA is protecting your privacy and confidentiality. If you share this concern, there are more private ways to follow us on Twitter or other platforms (such as using an RSS feed), which would eliminate your having a public link to our content. You are welcome to use your own discretion in choosing whether to follow us; please note that your therapist may not follow you back. This is only in order to safeguard your privacy. If there are things from your online life that you wish to share with your therapist, please bring them to your sessions where you can view and explore them together during the therapy hour.

### *Interacting*

Please do not use messaging on social networking sites such as Twitter, Facebook, LinkedIn, Pinterest, Instagram or similar sites to contact your therapist. These sites are not secure nor HIPAA compliant, and your therapist may not read these messages in a timely fashion. Do not use wall postings, @replies, or other means of contacting your therapist in public online; engaging this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact your therapist between sessions, the best way to do so is by phone and/or voicemail. Direct email or text is second best for quick, administrative issues such as changing appointment times; please see the email/text section below for more information regarding email and text interactions.

## Use of Search Engines

It is not a regular policy of our practice to search for clients on Google, Bing, Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If your therapist has a reason to suspect that you are in danger and you have not been in touch via usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations, and if your therapist ever resorts to such means, they will fully document it and discuss it with you when you next meet for session.

## Location-Based Services

If you used location-based services (LBS) on your mobile phone, you may wish to be aware of the privacy issues related to using these services. Laurel Fay and Associates is not placed as a check-in location on any location-sharing site such as Foursquare. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a therapy client due to regular check-ins at our office on a weekly basis. Please be aware of this risk if you are intentionally “checking in,” from our office or if you have a passive LBS app enabled on your phone.

## Email/Text

At our practice, we ask that you use email or text only to arrange or modify appointments. Please do not email or text your therapist content related to your therapy sessions, as email/text is not completely secure or confidential. If you choose to communicate with your therapist by email/text, you do so with the full acknowledgement that all emails/texts are retained in the logs of your and our Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails/texts your therapist receives from you, as well as any responses that are sent to you become a part of your legal record. Thank you for taking the time to review our Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to the attention of your therapist so that your concerns can be discussed.

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I understand that my signature below indicates that I have read, understand and agree to this policy.  
I have had the opportunity to ask questions and have those questions addressed.

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Signature

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Date

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Signature

---

Date

Rev 3/2017

