Client Contact Information

Client Name: _____ Date of Birth: _____

Parent or guardian (if client is under the age of 14): _____

Mailing address: _____

City/State/Zip: _____

Emergency Contact: _____

Client-Therapist Contact:

While most communication should occur in person, you and I will need to have contact outside of your therapy sessions at times. In the event of inclement weather or if I am ill or have an emergency that prevents me from attending our session, I will make every effort to contact you as soon as possible to reschedule your appointment. Please indicate which method(s) you would like me to use to contact you:

Cell Phone: YES ___ NO___ Number: _____ Please text me only ___

Please call me only ___

Text or phone call is okay ___ (y or n)

It is okay to leave a voicemail ___ (y or n)

Home Phone: YES ___ NO ___ Number: _____ It is okay to leave a voicemail ___ (y or n)

Email: YES ___ NO ___ Email Address: _____

What is your preferred method(s) of communication? Cell Phone _____ Home Phone _____ Email _____

By signing, I am giving permission for the above-mentioned method(s) to be utilized by Tammy Ahn Hock, LPC, LLC for the purpose of communicating about my treatment:

Signature: _____ Date: _____

Tammy Ahn Hock, LPC, LLC
150 South Warner Road, Suite 130, King of Prussia, PA 19406
215.280.4958
Tammyhockcounseling@gmail.com
www.tammyhockcounseling.com

Disclosure, Treatment and Fee Agreement

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Therapist's Degrees, Credentials and Certifications:

Bachelor of Arts (Social Behavior), 2001

Master of Science (Counseling and Human Relations), 2006

Licensed Professional Counselor, 2013

(In the state or Pennsylvania, a Licensed Professional Counselor must complete 60 hours of graduate coursework and hold a graduate degree from an accredited college, obtain 3,600 hours of supervised clinical experience, and pass the National Counseling Exam (NCE). A minimum of 30 hours of continuing education approved by the National Board of Certified Counselors (NBCC) every 2 years is required for license renewal.)

Certified Advanced Alcohol and Drug Counselor, 2014

(In the state of Pennsylvania, a Certified Advanced Alcohol and Drug Counselor must hold a graduate degree from an accredited college, obtain 180 hours of education related to substance use disorders and co-occurring disorders, obtain 2,000 hours of experience working with the addicted/co-occurring population, and 100 hours of supervision. A minimum of 40 hours of continuing education approved by the Pennsylvania State Certification Board every 2 years is required for certification renewal.)

Certified Clinical Trauma Professional Level II, 2021

(A Level II Certified Clinical Trauma Professional must hold a graduate degree from an accredited college, be an independently licensed mental health professional, and complete 48 hours of trauma training including 24 hours of training in complex trauma. A minimum of 12 hours of continuing education in related to trauma every 2 years is required for certification renewal.)

Client Rights and Important Information:

Method of Treatment: You have the right to receive information about the methods of treatment, techniques used, duration of therapy (if known), and the fee structure. At any time, you have the right to seek a second opinion or terminate treatment. Please be advised that in a professional relationship, sexual intimacy is never appropriate and should be reported to the board of licenses, registers, or certifies the licensee, registrant or certification holder.

Sessions and Fees: Sessions are 50 minutes in length. Session rates vary. Payment for each session is due at the time of each therapy session and must be in the form of cash, debit or credit card. A receipt of payment will be offered and invoices will be provided to you upon request. You are responsible for providing a minimum of 24 hours of notice if you need to cancel your session. You may be charged for last-minute cancellations or no shows. Please refer to the Cancellations and Inclement Weather form regarding fees for missed sessions.

Confidentiality: Sessions are confidential. Information regarding treatment may be shared with a third party only with written consent from the client. Exceptions to confidentiality include when the client is in imminent danger of harming self or others or when child abuse is suspected. In the case of working with minors, legal guardians will know about the treatment, however, privacy will be respected as much as possible. When treating couples and/or families, confidentiality among family members is not a guarantee.

Emergencies: In a mental health emergency, dial 911 or go to your nearest urgent care or emergency center (resources are available on the practice website). If you choose to contact your therapist, your call will be returned as soon as possible. Please note that, in the event that your therapist is not available, no on-call clinician will be available.

I have read the preceding information and it has also been explained to me by the therapist. I understand my rights as a client or as the client's responsible party. I agree to the conditions stated above, including policies regarding fees, insurance, cancellations, confidentiality, crisis plans, and client rights.

Print Client's Name: _____

Client or Responsible Party's Signature: _____

Date: _____

If signed by Responsible Party, please state relationship to client: _____

Notice of Privacy Practices

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In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this notice describes how health information about you is protected, and also how it may be used and disclosed. During the process of providing services, Tammy Ahn Hock, LPC, LLC, will obtain, record and use mental health and medical information about you that is protected health information. Ordinarily, that information is confidential and will not be used or disclosed, except as described below.

USES, DISCLOSURES, AND COMMUNICATIONS OF PROTECTED INFORMATION

A. General Uses and Disclosures Not Requiring the Patient's Consent.

1. **Treatment:** Treatment refers to the provision, coordination, or management of healthcare (including mental healthcare) and related services. During treatment, the provider may consult with other providers, without identifying you by name, and also not disclosing any other identifying information about you, in order to ensure the best possible care for your concerns.

2. **Payment:** Payment refers to the activities undertaken by the provider to obtain or provide reimbursement for the provision of healthcare. For example, the provider will use your information to develop accounts receivable information, to bill you, and with your consent, to bill third parties. If you elect to have a third party pay for your treatment, the information billed to your third party may include information that identifies you as well as your diagnosis, type of service, date of service, and other information about your condition and treatment.

3. **Contacting the Patient:** The provider may contact you to remind you of appointments, or change or cancel appointments. The provider may leave messages on voicemail or with other parties, identifying the name and phone number of the provider. The provider will use best judgement in the details left on the voicemail. If you do not want the provider leaving messages, or you wish to restrict the messages in any way, please notify the provider in writing.

4. **Required by Law:** The provider will disclose protected health information when required by law or when necessary for healthcare oversight. This includes, but may not be limited to: (a) reporting child abuse or neglect; (b) when court ordered to release information; (c) when

there is a legal duty to warn or take action regarding imminent danger to others; (d) when the patient is a danger to self or others or gravely disabled; (e) when a coroner is investigating the patient's death.

5. **Family Members:** Except for certain minors, protected health information cannot be provided to family members without the patient's consent. In situations where family members are present during a discussion with the patient, and it can be reasonably inferred from the circumstances that the patient does not object, information may be disclosed in the course of that discussion. However, if the patient objects, protected health information will not be disclosed.

6. **Emergencies:** In life-threatening emergencies, the provider will disclose information necessary to avoid serious harm or death.

B. Patient Authorization or Release of Information:

The provider may not use or disclose protected information in any other way without a signed authorization or release of information. When you sign an authorization, or a release of information, it may be later revoked, either in writing or verbally. The revocation will apply, except to the extent that the provider has already taken action in reliance thereon.

C. Alternative Means of Receiving Confidential Information:

You have the right to request that you receive communications of protected health information from the provider by alternative means or at alternative locations. For example, if you do not want the provider to mail statements or other materials to your home, you can request that this information be sent to another address. There are limitations to granting such requests. You may be required to pay for any additional costs that may be associated with such a request.

Protection of Confidential Information:

The provider has taken steps to protect the confidentiality of your information, including the use of name-codes, password protection of computer files, locked file cabinets, paper shredding, and other security measures. Your files will be destroyed (shredded or incinerated) when past the time required for the maintenance of such records.

I hereby acknowledge that I have received a copy of the provider's Notice of Privacy Rights.

Client or Parent/Guardian Signature: _____

Date: _____

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Informed Consent to Telehealth Consultations

By signing below, I certify that I give consent to receive behavioral health services via telehealth that includes both audio and video interactions with Tammy Ahn Hock. I understand the following:

1. The purpose is to assess and treat my behavioral health condition.
2. The telehealth consultation is done via telephone or through a two-way video link-up where my therapist, Tammy Ahn Hock, can see my image on the screen and hear my voice. Such a consultation may not be equal to a face-to-face visit.
3. I can ask questions and seek clarification of the procedures used in telehealth technology.
4. I can ask that the telehealth session be stopped at any time.
5. I know there are potential risks with the use of this technology. These include but are not limited to:
    a. Interruption of the audio/video link.
    b. Disconnection of the audio/video link
    c. A picture that is not clear enough to meet the needs of the consultation
    d. Electronic tampering.

If any of these risks occur, the consultation may need to be stopped.

6. The session will be private, much like the sessions held in the office setting. **I will inform my therapist if I am allowing anyone else to be with me for the consultation.**
7. I understand that my therapist is limited in their ability to actively intervene if a situation arises where I feel suicidal or have impulses to self-injure. If my therapist is concerned for my safety, they may require face-to-face consultations going forward. Additionally, they may engage the assistance of others (other family members, police, etc.) to intervene on my behalf to ensure my safety.
8. I understand that the consultation will not be videotaped or recorded by my therapist and I agree to likewise not record the session using audio or visual technology.
9. I understand that I am financially responsible for payment for services rendered via telehealth as if those services were delivered in a face-to-face meeting in the traditional office setting. **Failure to be available to my therapist for the scheduled appointment may result in the standard no-show fee charge applied to your account** (refer to the *Cancelations and Inclement Weather* form).
10. I understand that **I must dress as I would if I were attending an in-person session** and agree not to wear revealing or inappropriate clothing (i.e. pajamas), be "half-dressed" (i.e. fully dressed only from the waist up), or wear clothing that displays potentially offensive language or images.
11. **I understand that the environment I am in during these sessions is to be as therapeutic as possible.** Distractions such as background music or other noise, offensive or loud images that the therapist can see, eating meals/snacks, etc. may result in the session being terminated or delayed.
12. I understand that if I am uncomfortable with this process, I may terminate the session at any time without consequence.

I, the undersigned client, have read this form or had it read to me and I understand and agree to its contents. I agree to participate in ongoing telehealth sessions as long as my therapist feels it is in my best interest and is a reasonable substitution for face-to-face sessions in the traditional office setting.

Signature: _____Date: _____

Printed Name: _____

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Missed Appointments, Cancellations and Inclement Weather

In the event that your therapist decides that it is necessary to cancel your appointment due to inclement weather, illness, emergency, etc., you will be notified as soon as possible and offered another session time. If you need to cancel your appointment for any reason, please provide a minimum of 24 hours of notice. It is important that cancellations be kept to a minimum, as missing too many appointments will likely interfere with the quality of your treatment.

By signing below, I acknowledge that I may be charged 50% of my session fee for a late cancellation and up to 100% of my session fee for a "no show" (missed appointment without notice) and that fees are due within 30 days of the missed appointment. I also acknowledge that failure to pay fees by their due dates may result in suspension or termination of services.

Signature: _____ Date: _____