22231 Mulholland Hwy., Suite 210
Calabasas, California 91302
(818) 224 – 4486
www.mentallyfitlife.com

CONSENT FOR TELEHEALTH TREATMENT AND POLICIES

Welcome to Mental Fitness Lifestyle, Inc., Dr. Allison Carter's private psychology practice. This document contains important information about professional services specific to TeleHealth Treatment and policies. Please read it carefully and write down any questions you may have so they can be discussed. Also, **please be advised, a "Consent for Treatment and Office Policies" Form, if not already on file, must be completed in addition to this Consent for TeleHealth Treatment and Policies Form.**

THE TELEHEATH THERAPEUTIC PROCESS

The benefits from TeleHealth psychotherapy, offered both via live streaming video and telephone, can be many, including easier access to care and the convenience of having sessions from a location of the client's choosing. TeleHealth services may involve the same risks of traditional, in-office services, in that sessions may result in the remembering of unpleasant events and arouse intense emotions of anxiety, sadness, anger, and depression. Unique to the risks inherent with TeleHealth therapy are factors related to the technology utilized, including interruptions, unauthorized access, and technical difficulties. In addition, while there is general consensus in outcome research that most people are helped when they are matched with the right therapist, there is no guarantee that TeleHealth therapy will lead to the desired results. TeleHealth Psychotherapy never includes any additional or outside relationships that may impair your therapists' objectivity, clinical judgement, or therapeutic effectiveness. Psychotherapy never includes any format of romantic or sexual relationship between clinician and patient. If you/your child has ever been approached about or coerced into such a relationship there is a potential legal, and an ethical, obligation by Mental Fitness Lifestyle, Inc. and its therapists to report this information to proper authorities.

To be successful, TeleHealth Psychotherapy requires a very active effort on the part of the client (and client's parent, if client is a minor). In order to be most successful, TeleHealth session preparation may require/include the following:

- Assuring client has a private space in which to conduct sessions, including no ability for others to hear/listen in through walls, doors, etc.
- The use of a telephone, Smartphone, tablet, or laptop computer
- Having a strong cell and/or internet connection
- Assuring client's private space for sessions has adequate lighting for TeleHealth video sessions
- Assuring client's private space for sessions has limited background noise and interference, including digital and notification interferences
- A set of headphones connected to client's telephone, tablet or laptop

Participation in and clinical/ethical appropriateness of TeleHealth Psychotherapy is strictly determined between the client (parent if client is a minor and consent is legally/clinically warranted) and the treating clinician. Furthermore, participation in TeleHealth therapy with Mental Fitness Lifestyle, Inc. and its clinicians is strictly voluntary (unless ordered by the court) and client's have the right to terminate sessions or overall treatment at any time.

By initialing and signing below, I acknowledge I have had a direct conversation with my/my child's clinician, during which I had the opportunity to ask questions in regard to TeleHealth Psychotherapy. I acknowledge my questions have been answered and the risks, benefits, policies and procedures have been discussed with me in a language in which I understand.

_____ My initial represents that I have read, understand, discussed and agree to the above stated policies related to the TeleHeath Therapeutic Process.

TELEHEALTH CONFIDENTIALITY

As with in-office sessions, all legal and ethical mandates for psychotherapy confidentiality are upheld by clinicians of MFL, Inc. throughout TeleHealth Psychotherapy sessions. Within certain limits, information revealed during therapy will be kept strictly confidential and will not be revealed to any person or agency without the client's written permission. **There are certain situations in which, as psychologists and therapists, the law requires information obtained during therapy, including TeleHealth sessions, to be reveled to other persons or agencies**. These situations are as follows:

1) If your therapist believes there is risk of you/your child self-inflicting serious harm or death, there is an ethical responsibility to give this information to appropriate persons in order to obtain the best care for you/your child and assure safety.
2) If you are a threat of grave bodily harm or death to another person who can be identified, and belief exists that the intent and means to carry out harm is present. A "Duty To Warn" law enforcement and the intended victim overrides confidentiality.
3) If your therapist becomes aware of physical, sexual or emotional abuse of a minor, or a situation of neglect or harm to a minor, a mandatory report must be filed with Child Protective Services.
4) If your therapist becomes aware that an elderly person or dependent adult is being abused a mandatory report must be filed with Adult Protective Services.
5) If a court of law issues a legitimate subpoena or your/your child's clinical treatment is court ordered.

Should any of these situations transpire during a TeleHealth Psychotherapy session, your/your child's therapist will make every effort to fully discuss it with you before taking any action and the minimal amount of information needed will be disclosed.

MFL, Inc. utilizes a scheduling service for all appointments made by patients, whether in-office or TeleHealth. In addition, for TeleHealth video sessions a videoconferencing network is utilized. Your information is kept strictly confidential within these services and employees of these services have agreed to a strict confidentiality policy that complies with HIPPA standards. Your signature on this consent form is acknowledgement that you were made aware that information you input into the scheduling service website, and that is used to generate any TeleHeath video sessions, is potentially known to the employees of the scheduling service company and in an electronic cloud where true, full confidentiality can not be guaranteed.

To maintain TeleHeath video session confidentiality, client agrees to not, and has addressed with any minor child client not to, share the provided TeleHealth Video Session link with anyone unauthorized to attend the appointment.

_____ My initial represents that I have read, understand, discussed and agree to the above stated policy.

_____ My minor child's initial represents that I have read, and discussed the above stated policy with him/her and he/she agrees to the above stated policy to the extent he/she is developmentally able to understand and provide consent.

To maintain TeleHeath video session confidentiality, client agrees to not, and has addressed with any minor child client not to, screenshot, photograph, or in any format for any length of time, take or maintain photographs of TeleHealth video sessions.

_____ My initial represents that I have read, understand, discussed and agree to the above stated policy.

_____ My minor child's initial represents that I have read, and discussed the above stated policy with him/her and he/she agrees to the above stated policy to the extent he/she is developmentally able to understand and provide consent.

To maintain TeleHeath phone session confidentiality, client agrees to not, and has addressed with any minor child client not to, third-way call or in any other format include a third party into the TeleHealth phone session without prior agreement between clinician and client/client parent.

_____ My initial represents that I have read, understand, discussed and agree to the above stated policy.

_____ My minor child's initial represents that I have read, and discussed the above stated policy with him/her and he/she agrees to the above stated policy to the extent he/she is developmentally able to understand and provide consent.

To maintain TeleHeath phone session confidentiality, client agrees to not, and has addressed with any minor child client not to, allow any third party in listen in on the TeleHealth phone session in any format without prior agreement between clinician and client/client parent.

_____ My initial represents that I have read, understand, discussed and agree to the above stated policy.

_____ My minor child's initial represents that I have read, and discussed the above stated policy with him/her and he/she agrees to the above stated policy to the extent he/she is developmentally able to understand and provide consent.

Should you choose to participate/have your child participate in any form of TeleHealth Psychotherapy, you are hereby made aware that your therapist and MFL, Inc. take every available precaution to assure confidentiality via these means of communication, but given the nature of the internet, cell services, e-mail, online networks,

etc. and similar technologies, complete confidentiality can not be guaranteed. Please address any concerns directly with your/your child's therapist.

_____ My initial represents that I have read, understand, discussed and agree to all of the above stated policies related to TeleHealth Confidentiality.

TELEHEALTH SESSIONS, SCHEDULING AND CANCELLATION POLICY

Mental Fitness Lifestyle, Inc. utilizes the same online scheduling service program for both in-office and TeleHealth therapy sessions. The patient/patient parent will schedule all appointments subsequent to the Intake Appointment via the HIPPA compliant scheduling program "Appointment Plus." TeleHealth video sessions will be hosted within the HIPPA compliant network "TherapySites." In signing this TeleHealth Consent and Policies Form I, the client/client parent/guardian, am acknowledging that neither Appointment Plus nor TherapySites is responsible for the delivery of healthcare, medical/psychological advice, or client care of any kind. I further acknowledge that my treating clinician does not have access to any or all of the technical information held by either of these platforms.

To schedule any format of TeleHeath session, the client/client parent will create an account by going to www.mentallyfitlife.com and clicking on "Schedule Appointment." From there client will be able to follow the prompts regarding creating an account, scheduling appointments, canceling appointments and adding your name to a wait list.

ALL TELEHEALTH THERAPY APPOINTMENTS MUST BE SCHEDULED AS SUCH IN ADVANCE OF THE APPOINTMENT DATE/TIME IN THE APPOINTMENT SCHEDULING PROGRAM (aka APPOINTMENT PLUS). For TeleHealth Phone Sessions, please include the contact phone number the therapist is to call for even if you believe the number already to be on file. Client must be able to receive incoming blocked calls on the TeleHealth phone number provided.

WITHOUT "TELEHEALTH PHONE" OR "TELEHEALTH VIDEO" BEING SELECTED BY THE CLIENT WHEN SCHEDULING TELEHEALTH SESSIONS, CLINICIAN WILL DEFAULT TO THE UNDERSTANDING THE SESSION IS IN-OFFICE, WITH ALL POLICIES AND PROCEDURES APPLYING TO THE SCHEDULED SESSION INCLUDING NO SHOW AND LATE CANCEL POLICIES.

All scheduled appointments are considered confirmed. TeleHealth sessions in the scheduling service are forty-five (45) minutes in length unless otherwise specified. Once a TeleHealth appointment is scheduled in the scheduling service, you will be expected to pay for it unless you cancel the session with twenty-four (24) hours advance notice. Failure to cancel with twenty-four (24) hour advance notice or a "No Show" to a scheduled appointment will be billed at the standard session rate. 'Twenty-four hour notice' is defined as 24 hours from the time of your scheduled appointment and not simply a calendar day beforehand. "No Show" for TeleHealth sessions, is defined as not answering the incoming telephone call at the time of appointment/time of incoming call or not joining the TeleHealth video network link provided at the time of appointment/time of clinician commencing/joining room. All charges for Late Cancellations and No Show TeleHealth appointments will be due and payable in accordance with payment procedures and billed to the credit card on file.

Note that psychological treatment emergencies do occur that may impact a therapist's workday. In the event that a treatment emergency will impact your TeleHealth session time (late start time, required cancellation)

every effort to contact you will be made, but this will not always be possible given the nature of TeleHealth formats and your clinician's workday schedule. Should your TeleHealth session begin later than its scheduled time due to a treatment emergency your therapist will still conduct a full 45-minute TeleHealth session. Should you need to leave the TeleHealth session at the originally scheduled end time, the session will be prorated to the length of time from when the therapist becomes available to the TeleHealth session original end time. There will be no fee charged or credited for therapist cancelled sessions resulting from a treatment emergency.

_____ My initial represents that I have read, understand, discussed and agree to the above stated policies related to TeleHealth Sessions, Scheduling and Cancellation Policies.

TELEHEALTH PROFESSIONAL FEES & PAYMENT PROCEDURES

MFL, Inc. TeleHealth therapy sessions usually involve weekly Standard Session appointments that are 45 minutes in duration (this time frame includes time you may require to establish subsequent appointments, make payments, ask questions, etc.) but may be longer or more frequent. The current TeleHealth Intake Session, a one-time 60-minute session required to commence treatment, fee is $_____ and the current TeleHealth Standard Session fee is $_____. MFL, Inc. reserved the right to raise TeleHealth session rates on a yearly basis.

MFL, Inc. TeleHealth professional fee policies require that each patient (patient parent for minors) provide a credit card to be kept on file. MFL, Inc. reserves the right to process the card on file for all session fees twenty-four (24) hours or less prior to any scheduled appointment time and anytime thereafter.

Mental Fitness Lifestyle, Inc. does not take insurance, is not on any insurance panels, and does not bill any insurance companies directly. Therapy expenses are the patient/patient parent's responsibility regardless of insurance coverage. If you would like an invoice to help facilitate obtaining payment reimbursement from your insurance company, it can be provided to you upon your written request. Please note, not all insurance companies cover TeleHealth Psychotherapy sessions in the same manner they cover in-office sessions. Determining coverage for TeleHealth services is at the sole discretion of the client. Mental Fitness Lifestyle, Inc. and its therapists will not provide any information directly to a client's insurance company.

_____ My initial represents that I have read, understand, discussed and agree to the above stated policies related to Telehealth Professional Fees & Payment Procedures.

TELEHEALTH CONTACT PROCEDURES

While the MFL, Inc. offices may be open and providing both in-office and/or TeleHealth Psychotherapy sessions, therapists are often with clients back-to-back and are not always able to answer the phone, reply to emails, or notify clients if sessions are running behind. **In the case of a true psychological emergency you are hereby advised to call 911 and a local emergency response team or hospital.** When clinicians are unavailable, telephone calls are answered by voice mail that is checked as promptly as possible during non-patient hours. Every effort to return your voicemail within 2 business days is made. If you have not received a return call within 2 business days please make the assumption your voicemail was not received and call again. All non-emergency calls/emails received during a weekend or on a holiday will be returned within 2 business days of business resuming.

All emergency calls/emails received during a weekend or on a holiday will be returned as soon as they are retrieved. **You are hereby advised that if experiencing a true clinical emergency you should not wait for a phone call reply from your therapist prior to contacting 911 or another means of emergency response.**

Email is never to be used or relied upon as an emergency form of communication during a true clinical emergency.

If a family member is threatening violence or suicide, you need to call 911. Additional numbers that may be helpful include: California Youth Crisis Line (800) 843-5200, Los Angeles County Crisis Line (800) 854–7771, Ventura County Crisis Team 1-866-998-2243, Child Abuse Hotline (800) 540-4000, Domestic Violence Hotline (322) 681-2626, Elder Abuse Hotline (800) 992-1660 and Suicide Prevention Center (310) 391-1253.

Incoming phone calls from your therapists phone will be received as "Blocked." You must be able to receive blocked calls on the phone number you keep on file with your clinician, Mental Fitness Lifestyle, Inc., and in your appointment scheduling program profile. Should your therapist's phone number ever be displayed during an incoming call, and it not be the office phone number of (818) 224-4486, it is requested that you delete said phone number from your call log and consider it a private number not to be utilized directly.

In the event your therapist is unavailable for an extended time (vacations), you will be provided with the name and contact information of a trusted colleague whom you can contact in emergency situations.

_____ My initial represents that I have read, understand, discussed and agree to the above stated policies related to Contact Procedures.

Your initials and signature herein acknowledges that you have read and understand each of the above explanations regarding the TeleHealth therapeutic process, confidentiality, professional fees, appointment scheduling, cancellation policies, contact procedures and patient/patient parent responsibilities. You agree to enter/have your child enter into a TeleHealth Psychotherapy relationship with Mental Fitness Lifestyle, Inc. and your assigned therapist under the terms outlined above.

Patient's Name: _____

Signature (parent's if patient is a minor): _____ Date: _____

Therapist' Name: _____

Therapists Signature: _____ Date: _____