Thank you for selecting Jenda Family Services Outpatient Clinic.

To help us meet your therapy needs, please fill out this form **completely**. If you have any questions or need assistance, please ask and we will be happy to help.

JENDAFAMILYSERVICES

Date_____

Client Information

Check Appropriate Box: ☐ Minor **or** Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

First Name_____ Middle Initial_____ Last Name_____

DOB____/____/____ Soc Sec#____/____/____ Race _____

Home Phone_____ Cell Phone_____ Star (*) Primary

Address_____City_____St_____Zip_____

Employer_____ Position_____ Work Phone_____

Employer Address_____City_____St_____Zip_____

Adult Probation Only:
Family Size _____ Number of Dependents _____ Monthly Income $_____

Allergies_____

Person to Contact in Case of Emergency_____
Relationship to client_____
Phone_____ Address_____

Non-Family Member Contact_____
Relationship to client_____
Phone_____ Address_____

Who is responsible for the client's medical care? _____

Whom may we thank for referring client? _____

Insurance/Medicaid Information

Insurance Company_____

I.D. #_____ Group # _____

Name of Insured_____ Relationship to Client_____

DOB____/____/____ Soc Sec# ____/____/____ Phone Number _____

Address _____

Employer _____

(Please complete back side of this information sheet)

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No If YES, complete the following:

Insurance Company_____

I.D. #_____ Group # _____

Name of Insured_____ Relationship to Client_____

DOB____/____/____ Soc Sec# ____/____/____ Phone Number _____

Address _____

Employer _____

Authorization and Release

I certify that the information provided above is true and correct to the best of my knowledge and belief. With my written consent, I authorize Jenda Family Services to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health practitioners. With written consent, I authorize and request my insurance company to pay directly to the physician's office, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I understand I am responsible for all copays, deductibles, co-insurance, and balances. I personally agree to pay for any and all services provided to me at the rates in effect during the time services are render unless other arrangement with the office have been made. I understand and agree that my bill for services rendered is due and payable at the time of service and that I am ultimately responsible for any unpaid balances. I understand and agree that any cellular or land line phone numbers and email addresses provided by myself to this office and to any of our service providers, now and in the future, may be used as a means to contact me, and that this office and our service providers may leave messages for me I also agree that this office and any service providers may contact me by sending text messages and emails to any phone number or email address I provide to this office or service providers and I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communications.

X _____
Signature of Client Date

X_____
Parent/Guardian signature, if Client is a minor Date

JENDAFAMILYSERVICES

INFORMED CONSENT

Before we start therapy together, there are some things that you should know about the therapeutic process and about our office. In legal terms, this is called "Informed Consent". This information will help you, the client, understand what to expect.

Your Privacy and Confidentiality

All our work together – our conversations, your records, and any information that you give to us – is protected by something called HIPAA. HIPAA stands for Health Insurance Portability and Accountability Act. This gives patients' rights over their health information, including rights to examine and obtain a copy of their health records and to request corrections. It also establishes national standards to protect individuals' medical records and other personal health information. This means that in most cases, the law protects you from having information about you given to anyone without your knowledge and permission. Our office respects your privacy. There are, however, some exceptions to your privacy.

Harm Disclosure

If you believe there is a risk you might harm yourself or someone else, we may be required to contact the authorities or the other person to give them the opportunity to protect you. If you are abusing children, an elderly person, or a disabled adult, we must notify the authorities. Also, if you become involved in any lawsuit in which your mental health is an issue – for example, a custody dispute or injury lawsuit in which you claim compensation for emotional pain and suffering- then the court or the lawyers may insist upon and may obtain your information from us. Similarly, you will lose the protection of your privilege if you file a complaint against us with the state licensing board.

If we suspect you or any other individual has been harmed or is at risk of being harmed by abuse or neglect, we are obligated as mandatory reporters to contact the Abuse or Neglect Hotline. Within this call we may share your identifying information, the information disclosed in the allegation and the alleged abuser. If you have further questions, please ask your therapist.

Financial Confidentiality

The financial part of our relationship also imposes some confidentiality limits. If you are using insurance or another 3rd party payer, our office must share certain information with them, including (but not limited to) your diagnosis and the times of your sessions. If there is a managed care company, they may require us to provide additional information, such as your symptoms and your progress. You should also understand that insurance and managed care information is often stored in national computer databases. By your signature below, you authorize our office to provide information to your insurance and managed care companies to the extent necessary for them to pay for your services.

Potential Side Effects of Therapy

You should know that therapy is not always easy. You may find yourself having to discuss very personal information. You could find those conversations difficult and embarrassing, and you might be very anxious during and after such conversations. As you learn more about yourself, you might encounter increased conflict with friends, co-workers, and family members. It is possible that you might become somewhat depressed. Therapy is intended to alleviate these problems, but sometimes as you get to the root of some things, you may feel them even more acutely than in the past. We may also ask you to do some things that might, at first, make you feel uncomfortable or awkward. Sometimes therapy requires trying new and unfamiliar ways of doing things. You will always be free to move at your own pace. We will work with you to make changes, but we cannot promise anything about the results you will obtain. The outcome you achieve will depend on many things.

If we believe that your problem requires knowledge that we do not have in our office, we may refer you for a consultation with someone with specific training or experience. We will discuss any such referral with you before we act.

At the very beginning we will create a treatment plan with you. This means that we will look at what you would like to change, what we will do to change it, how we will know you are succeeding, and how long it will take. Treatment plans will be reviewed regularly with you.

Our Office Policies

Therapy sessions usually last between 45 and 60 minutes depending on your treatment. Sessions must end promptly. If you have a co-payment or private pay, payment is due at the time of your appointment. We accept cash, checks and credit cards for payments.

Our phone is answered regularly from **9 am- 6 pm Monday through Thursday and Fridays 8 am – 2 pm.** Messages from the answering machine are checked regularly, and whenever possible we try to return phone calls the same day. If we have not returned your call within 24 hours, please try again as your message may have been lost. Messages left after 5 pm are not checked until 8 am the next business day. If you have an emergency after that time, call 911, or go to an emergency room.

When we are out of the office for several days, the messages you leave may be answered by another therapist. We will probably not have discussed your case with that person, but he/she will make every effort to be helpful to you in our absence.

Your therapist will meet with you on a regular basis. If you are going to miss an appointment, please contact our office at least 24 hours in advance of the appointment. If you miss a scheduled appointment, it is your responsibility to call the office to schedule another appointment if you wish to continue your therapy effort. After a missed appointment, if you do not call our office within 10 days to reschedule, your therapist will accept that as your notice that you have terminated therapy with our office.

Late Policy

If a client is more than 15 minutes late, it is at the discretion of the therapist if they are seen or not. With evaluations, if the therapist believes that there is adequate time, the evaluation shall be completed to the extent that time allows.

Cancellations and No Shows

Two missed sessions will result in you being removed from the therapist's schedule. You will need to reach out to the therapist to determine ongoing scheduling. Providing at least a 24 hour notice of a cancellation will not impact your attendance rate.

Three no-shows and/or cancellations may warrant a discharge, and referral to other therapy services. These may be consecutive or repetitive no-shows and/or cancellations. Referral to other therapy services is at the discretion of the individual therapist.

If a client has been discharged through the no call/no show policy, a letter will be sent to their current address. The therapist will attempt to discuss the referral to another provider with both the client and their referring source.

The Internet, Electronic Communication and Patient Portal

You may use email or text messaging to communicate with your therapist. If you do choose to communicate via email or text, remember that email and text communications may not be private. Email is, by its nature, subject to pass through a variety of email servers and thus subject to interception by unknown parties. Text messages sent via third party applications may also pass-through various servers. Email and text communication with our office should be limited to administrative and logistical matters; your therapist will NOT use email to discuss important personal and therapy matters. Jenda Family Services utilizes the Valant Patient Portal for secure communication please see Patient Portal Consent for more information.

I understand and I accept the limited privacy of email and text message communications. I authorize your office to communicate with me at the below listed email address.

Email Address: _____

Client or Guardian Signature: _____ Date: _____

Other Office Policies

If a client threatens to self-harm or harm others, a report will be filed by the therapist. Proper steps will be taken to assure that clients do not leave this office to harm others, or themselves.

Weapons are not allowed within the clinic. If a weapon is to be found on the person, that person will be asked to dispose of it, leave the premises, or the appropriate authorities will be notified.

All staff will be equipped to handle urgent situations such as bomb threats, active shooter, someone who is a threat to themselves or others, and any other emergencies that may arise.

Any physical or verbal violence or threats of violence will not be tolerated; should these situations arise; the appropriate authorities will be notified at the therapists or support staff's discretion.

Our therapists are not allowed to accept gifts from clients. While we appreciate your thoughtfulness, we are prohibited by the canons of our profession not to accept gifts from clients.

Similarly, our professional practice standards prohibit our therapists from accepting requests to connect or to be "Friends" on internet sites such as Facebook, Twitter, Instagram, Snap Chat, etc.

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Similarly, our professional practice standards prohibit our therapists from accepting requests to connect or to be "Friends" on internet sites such as Facebook, Twitter, Instagram, Snap Chat, etc.

By your signature below, you authorize our office to designate an appropriate professional to serve as custodian of your record, and who will assume possession of, and responsibility for your treatment record in the event of your therapist's death or disability. Notice will be posted, as necessary on your therapist's web page and telephone voice mail.

Your Treatment

Type of treatment requested and planned: _____

Your therapist's customary fee is _____ per session.

Your Copay (if you are using a third-party payer) is _____per session.

I have read the Informed Consent, I understand it, and I agree to the terms described. I agree to pay for therapy services as indicated at the time of service, and if using a third party (e.g., insurance) payer, you agree that our office may provide any information to your insurance carrier and managed care company necessary to consider, process, and approve payment for services.

Further, I agree that all charges are, finally, my responsibility, and that in the event my insurance carrier refuses payment, I agree to pay all amounts due. Your therapist may refuse to schedule an appointment until you have paid any outstanding balance you have with our office. If you are unable to pay for your services in the future, you understand and agree that your counselor will be unable to continue services. In that event, your therapist will provide you with a referral to another provider more readily able to work within your budget.

Client Signature: _____ Date: _____

Parent/Guardian Signature if Client is a minor: _____

Staff Signature: _____ Date: _____

JENDA FAMILY SERVICES

Notice of Privacy Practices Acknowledgement:

Our Notice of Privacy Practices provides information about 1) the privacy rights of our patients; and 2) how we may use and disclose protected health information about our patients.

Federal regulations require that we give our patients or their authorized representatives our Notice before signing this acknowledgment. A copy of this form is available in our Jenda Family Services Outpatient Clinic waiting room and you may receive a copy of the HIPAA notice form upon request.

Your signature below indicates that you have reviewed and understood the HIPAA notice form.

Signature: _____ Date: _____

Permission to Observe Sessions and Discuss Case Information:

Jenda Family Services Outpatient Clinic serves as a training facility for Masters' in Counseling Internship Students. It is possible that interns will on occasion be sitting in on sessions. If this should occur, the therapist will ask for permission prior to the beginning of the session if someone can join for observation and/or to provide assistance. You may decline at that time. All interns within Jenda Family Services Outpatient Clinic are bound by confidentiality agreements and HIPAA regulations.

Signature: _____ Date: _____

Consent for Treatment:

I hereby consent to mental health and/or substance abuse treatment to be provided by Jenda Family Services. This includes assessment and treatment procedures as appropriate. I understand that treatment options will be discussed with me and that I have a right to participate in decisions about treatment.

Client Name: _____ Client Signature: _____

Parent/Guardian Name:_____ Parent Signature:_____

Staff Signature: _____ Date: _____

JENDAFAMILYSERVICES

Clients Rights and Responsibilities

Jenda Family Services recognizes certain rights and responsibilities for persons served. Clients are asked to read, or have read to them, and sign the rights and responsibilities document, which is placed in the clinical record. A copy is provided to the client.

As a client of Jenda Family Services, you are entitled to all legal and civil rights granted by Federal and State Constitutions and Laws. In addition, clients have the right:

1. To not be subjected to verbal, physical, sexual, emotional or financial abuse; harsh or unfair treatment.
2. To be treated with dignity and respect;
3. To receive prompt and professional services;
4. To know the credentials and training of the persons providing services;
5. To reasonable accommodations for disabilities;
6. To expect staff to abide by client confidentiality and privacy regulations and to receive a copy of the Privacy Practices at Jenda Family Services;
7. To a timely review of information contained in the clinical record in order to facilitate decision-making. Requests can be made verbally or in writing to the Clinical Director or their designee who will respond within 5 working days of the request;
8. To participate in treatment planning with the treatment team in order to express preferences and expected treatment outcomes;
9. To request a written explanation within ten (10) working days, and expect a written response within five (5) working days, if you are refused services while in treatment;
10. To voice complaints or file grievances without discrimination or reprisal and to have those complaints and grievances addressed;
11. To file a complaint or grievance with the State Department of Health and Human Services, Division of Public Health, Investigations, 10033 "O" St, Lincoln, NE 68508, 402-471-0175;
12. To refuse or terminate services, though refusal may lead to discharge from the program;
13. To examine the results of the most recent survey of the facility conducted by representatives of the Department of Health and Human Services Regulation & Licensure.

Client Responsibilities

1. As our client, your responsibilities include the following:
2. To treat agency staff and clients with dignity and respect;
3. To arrive at your appointments on time or give timely notice of cancellation;
4. To work cooperatively and straightforwardly with staff;
5. To participate in all scheduled treatment activities
6. To uphold the terms of the financial agreement; pay for all services not covered by a third party.
7. To undergo medical, psychiatric or psychological examinations as requested
8. To authorize the program to secure medical services in the event of medical emergency;
9. To pay for any damage deemed to be intentionally inflicted upon agency staff or other client's property;
10. To follow the rules and program established for your treatment;

Rules (18-006.06) for all programs include, but are not limited to, the following:

Over

1. Possession or use of drugs or paraphernalia on Jenda Family Services property and/or at Jenda Family Services supervised activities is not allowed;
2. Possession of weapons including guns and knives on Jenda Family Services property and/or at Jenda Family Services supervised activities is not allowed;
3. Physical or verbal violence or threats of violence will not be tolerated; should these situations arise, the appropriate authorities will be notified at the clinician's discretion.
4. Sexual contact or harassment on the premises is not allowed;
5. Respect the right of other clients, including the right to confidentiality.

Agreement and Release

The undersigned hereby acknowledges having read, understood, and received a copy of this Clients Rights and Responsibilities, and agrees to meet those responsibilities.

The undersigned also agrees to release and hold harmless Jenda Family Services, its agents and employees, from any and all liability for injuries sustained by the me (client) while on the premises or participating in any program or activity of Jenda Family Services, or resulting from any actions or Jenda Family Services, its agents or employees.

I (client) understand that my violation of this agreement or the program's rules may result in my discharge form the program or other disciplinary action.

Client Signature _____ Date_____

Parent or
Legal Guardian
Signature_____ Date_____

Witness_____ Date_____

JENDAFAMILYSERVICES

Advance Directive

An advance directive is meant to help you plan ahead. The Advance Directive will let us know how you would like us to handle your medical file in the event you are unable to direct us. It is used to guide either your loved ones and/or health care team. You may choose to appoint two people to direct us **OR** the bottom allows us the option to destroy your file in five years.

I, _____,

appoint _____,

whose address is _____, and whose telephone number is _____, as my executor of medical information.

If my first choice is unable, unwilling, or not reasonably available to act as my attorney in fact I appoint _____,

whose address is _____, and whose telephone number is _____, as my successor attorney in fact for health care and all medical information possessed by Jenda Family Services Outpatient Clinic.

Client or Guardian Signature: _____ **Date**: _____

OR

I acknowledge that I refuse to sign at this time, and this office may choose to destroy this file after five years if I should become incompetent and no one has been appointed as my medical guardian.

Client or Guardian Signature: _____ **Date:** _____

JENDAFAMILYSERVICES

PAYMENT IS REQUIRED AT TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE BETWEEN YOU AND JENDA FAMILY SERVICES

INSURANCE RELEASE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Jenda Family Services to release information acquired in the course of my evaluation or treatment to any pertinent insurance company.

AUTHORIZATION TO PAY BENEFITS DIRECTLY TO JENDA FAMILY SERVICES: I hereby authorize payment directly to Jenda Family Services of any or all benefits due under the terms of this insurance policy for services rendered.

I acknowledge that I am responsible for 100% of each service rendered at Jenda Family Services Outpatient Clinic. If my insurance changes I will notify all affected parties promptly.

ADDITIONAL FINANCIAL INFORMATION

I understand that I am financially responsible for any charges or authorized charges not paid by my insurance company, including co-payments, co-insurance, and deductible amounts. Billing insurance does not guarantee their payment. Furthermore, I understand that there will be a finance charge of 12% APR on amounts not paid after 30 days of insurance being cleared and that accounts with no payment after 90 days of final billing will be submitted to a Collection Service.

I agree:

Client/Guardian Signature Date Witness Signature Date

I do NOT agree and will pay for services without billing insurance:

If I choose to not use my insurance or do not have insurance, by my signature, I agree to pay for all services provided by Jenda Family Services. Furthermore, I understand that there will be a finance charge of 12% APR on amounts not paid after 30 days of insurance being cleared and that accounts with no payment after 90 days of final billing will be submitted to a Collection Service.

Client/Guardian Signature Date Witness Signature Date

JENDA FAMILY SERVICES

AUTHORIZATION FORM: Primary Care Physician

This form when completed and signed by you, authorizes Jenda Family Services to release or obtain protected information from your clinical record to the person you designate.

CLIENT NAME: _____

DATE OF BIRTH: _____

I Hereby Authorize and Direct that:

_____ **Jenda Family Services will send information to:** **EXPIRATION**: _____
Agency_____ Primary Contact _____
Phone Numbers_____ Fax Number_____
Address_____

_____ **Jenda Family Services will receive information from:** **EXPIRATION**: _____
Agency_____ Primary Contact_____
Phone Numbers_____ Fax Number_____
Address_____

This information is needed for the following purpose:

care coordination and collateral information

And, such disclosure shall be limited to the following information:

____	Evaluation Report	____	Medical History & Physical
____	Diagnosis	____	Social History
____	Treatment Plan	____	Progress Notes
____	Discharge Summary	____	Psychological Testing & Evaluation
____	Written and Verbal Communication	____	Legal Record

____ Other (please specify)_____

☐ No, I do not wish to have information shared with my Primary Care Physician.

SIGNED: _____ **DATE**: _____
(Client or Guardian)

I understand that information may include drug and/or alcohol use or abuse, or psychological care or psychiatric care and that this information will not be released to any other agency, individual or organization for any other purpose without written consent except as required by Federal or State Law, including 42 CFR Part 2 and HIPAA.

I understand that I may revoke this authorization at any time by sending written notice to Jenda Family Services. If I do so, I know that it cannot apply to any information that had been released before receipt of my written notice. I also agree that a photostatic copy of this release is valid as the original.

If signed by a person other than the client: My relationship to the client and my authority to consent and direct this authorization is as follows:

_____

SIGNED: _____ **WITNESS:** _____
(Client or Guardian)

DATE: _____ **DATE**: _____

JENDAFAMILYSERVICES

AUTHORIZATION FORM

This form when completed and signed by you, authorizes Jenda Family Services to release or obtain protected information from your clinical record to the person you designate.

I Hereby Authorize and Direct that: **CLIENT NAME**: _____

DATE OF BIRTH: _____

_____ **Jenda Family Services will send information to:** **EXPIRATION**: _____
Agency_____ Primary Contact_____
Phone Numbers_____ Fax Number_____
Address_____

_____ **Jenda Family Services will receive information from:** **EXPIRATION**: _____
Agency_____ Primary Contact_____
Phone Numbers_____ Fax Number_____
Address_____

This information is needed for the following purpose:

care coordination and collateral information

And, such disclosure shall be limited to the following information:

____	Evaluation Report	____	Medical History & Physical
____	Diagnosis	____	Social History
____	Treatment Plan	____	Progress Notes
____	Discharge Summary	____	Psychological Testing & Evaluation
____	Written and Verbal Communication	____	Legal Record
____	Other (please specify)_____		

I understand that information may include drug and/or alcohol use or abuse, or psychological care or psychiatric care and that this information will not be released to any other agency, individual or organization for any other purpose without written consent except as required by Federal or State Law, including 42 CFR Part 2 and HIPAA.

I understand that I may revoke this authorization at any time by sending written notice to Jenda Family Services. If I do so, I know that it cannot apply to any information that had been released before receipt of my written notice. I also agree that a photostatic copy of this release is valid as the original.

If signed by a person other than the client: My relationship to the client and my authority to consent and direct this authorization is as follows:

_____

SIGNED: _____ **WITNESS**: _____

DATE: _____ **DATE**: _____

PARENT/GUARDIAN SIGNATURE IF MINOR: _____ **DATE**: _____

JENDAFAMILYSERVICES

AUTHORIZATION FORM

This form when completed and signed by you, authorizes Jenda Family Services to release or obtain protected information from your clinical record to the person you designate.

I Hereby Authorize and Direct that: **CLIENT NAME**: _____

DATE OF BIRTH: _____

_____ **Jenda Family Services will send information to:** **EXPIRATION**: _____
Agency_____ Primary Contact_____
Phone Numbers_____ Fax Number_____
Address_____

_____ **Jenda Family Services will receive information from:** **EXPIRATION**: _____
Agency_____ Primary Contact_____
Phone Numbers_____ Fax Number_____
Address_____

This information is needed for the following purpose:

_____

And, such disclosure shall be limited to the following information:

____	Evaluation Report	____	Medical History & Physical
____	Diagnosis	____	Social History
____	Treatment Plan	____	Progress Notes
____	Discharge Summary	____	Psychological Testing & Evaluation
____	Written and Verbal Communication	____	Legal Record
____	Other (please specify)_____		

I understand that information may include drug and/or alcohol use or abuse, or psychological care or psychiatric care and that this information will not be released to any other agency, individual or organization for any other purpose without written consent except as required by Federal or State Law, including 42 CFR Part 2 and HIPAA.

I understand that I may revoke this authorization at any time by sending written notice to Jenda Family Services. If I do so, I know that it cannot apply to any information that had been released before receipt of my written notice. I also agree that a photostatic copy of this release is valid as the original.

If signed by a person other than the client: My relationship to the client and my authority to consent and direct this authorization is as follows:

_____

SIGNED: _____ **WITNESS:** _____

DATE: _____ **DATE**: _____

PARENT/GUARDIAN
SIGNATURE IF MINOR: _____**DATE**: _____

Consent to In Person Treatment at Jenda Family Services Outpatient Clinic

Screening Questions

1.) Is anyone in the household currently sick? (fever over 100.4, cough, trouble breathing, sore throat, etc.)

2.) Has anyone in your household been in close contact with anyone known to have COVID-19 or who is under evaluation for COVID-19?

3.) Has anyone in your household traveled in the last 14 days (including any international travel or travel to US communities with community transmission)?

4.) Does anyone in the household have an underlying health condition? An underlying health condition is defined as a condition that can put a person at increased risk – a condition that impairs a person's lung or heart function or weakens their immune system.

*****If you answer yes to any of the top three questions you will be asked to leave Jenda Family Services immediately. Please contact your healthcare provider and the CDC for further information on steps to take.**

*****If you answer yes to the fourth question and you choose to continue with an in-person session, evaluation, etc. it is at your own risk.**

Safety Precautions

****The below safety precautions are subject to change as directed by the local health department****

1.) I agree to wash my hands upon immediate entry to the building for at least 20 seconds with soap and water or use a generous amount of hand sanitizer for at least 20 seconds.

2.)I agree to wear a mask at all times and will not remove it when in the presence of other people. This includes eating and drinking. Clients may use a straw to sip water from bottles. If you need to adjust your mask, please do so in the bathroom or outside. If you refuse to wear a mask or remove it, you will be asked to leave immediately.

3.) I agree to refrain from touching any unnecessary surfaces. I will also try to refrain from touching my nose, mouth, or eyes. If children are present, I will do my best to encourage them to follow the above listed precautions as well.

3.) I agree to remain at least 6 feet away from my provider as well as anyone else in the building at all times.

4.) Jenda Family Services has multiple options available for services including Telehealth. In person services are an option. Please discuss what options you are comfortable utilizing with your provider. Jenda Family Services utilizes the HIPAA compliant platform Zoom for video conferencing or phone calls.

5.) During the in person service any family members who are not essential to the service will be asked to wait in their cars. Jenda Family Services office and front area may be closed to visitors and non-essential personnel.

I, _____, consent to *myself*/_____ (minor) to be seen in person at Jenda Family Services office. I understand that Jenda Family services is following all CDC guidelines and taking all reasonable measures to ensure the safety of all clients and staff. I will do my best to follow all safety precautions listed above.

Client or Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____

JENDAFAMILYSERVICES

Tele-Behavioral Health Consent Form

Tele -Behavioral Health is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client who are not in the same physical location. This includes live audio and visual interaction.

As with any technology there are potential risks associated with the use of Tele-Behavioral Health. These risks include, but may not be limited to: ·

-Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment

-In very rare instances, security protocols could fail, causing a breach of privacy. Jenda Family Services utilizes a HIPAA compliant platform and utilizes every precaution to protect your privacy and personal information.

-It your responsibility, as the client, to ensure that sessions are conducted in a private space.

By signing this form, I understand the following:

1.) I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

2.) I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during my care at any time, without affecting my right to future care or treatment.

3.) I understand that I have the right to inspect all information obtained during a telemedicine interaction and may receive copies of this information for a reasonable fee. Sessions are not recorded.

4.) I understand that telemedicine may involve electronic communication of my personal medical information.

Patient Consent to the Use of Tele -Behavioral health:

I have read and understand the information provided above regarding telemedicine/tele-behavioral health, have discussed it with my clinician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my therapeutic care.

I hereby authorize Jenda Family Services to use Tele-Behavioral Health during my sessions and treatment.

Signature of Client/Guardian: _____ Date: _____

Witness Signature: _____ Date: _____

JENDAFAMILYSERVICES

Patient Portal User Agreement & Consent Form

Jenda Family Services - Outpatient Clinic offers secure viewing and communication as a service to clients who wish to view parts of their records and communicate with their therapist and support staff. Secure messaging can be a valuable communications tool but has certain risks. To manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works

The Patient Portal is intended as a secure online means for you to access your confidential medical record information. Please note that if you share your Patient Portal username and password with another person, this will allow that person to see your confidential medical record information. Your provider has no responsibility concerning any breach of your confidential medical record information due to your sharing or losing your username and password.

The Patient Portal is protected using industry standard security measures. While the security measures will reasonably protect your information and your use of the Patient Portal, if you have any concerns regarding the security of your information or the use of the Internet to access your medical record information, you should consider not creating a Patient Portal account.

If you use email services such as Yahoo and Google their email will not be encrypted and may not be secure for sending health information over the Internet.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect, and Jenda Family Services does our best to maintain electronic security and utilizes only HIPAA compliant software. Keeping messages secure depends on two key factors:

1.) The secure message must reach the correct email address.

2.) Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

It is imperative that we have your correct e-mail address and that you inform us of any changes to your e-mail address. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

JENDAFAMILYSERVICES

Types of Online Communication/Messaging

Online communications should never be used for emergency communications or urgent requests. For emergencies, please contact 911. For urgent requests please contact your therapist directly or call the main office at 402-474-0011 Option #3 for the Clinic.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand the Patient Portal User Agreement and Consent. I have read and understand the responsibilities and benefits of the Patient Portal and understand the risks associated with online communications between me and my clinician's office. I consent to the conditions outlined and I agree to keep my password confidential and notify the office if my email address changes at any time.

I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this Agreement. All my questions have been answered and I understand and concur with the information.

I certify that I am the age of 19 or older and have sole responsibility for mine or the minor child's medical care.

□ Yes.

□ I am the parent/guardian of the minor client.

□ I choose not to participate in Patient Portal currently.

□ I do not have an e-mail address.

□ I do not wish to share my E-mail address.

The email address I wish to use to access the Jenda Family Services Patient Portal is below:

Email Address: _____

Client Name: _____

Parent/Guardian Name: _____

Signature: _____ **Date:** _____