Let's Conquer This, LLC
Alyssa Beer, LCSW, CFRC

You've just taken a very positive and exciting step to begin sessions, and I'm happy to be a part of it! Enclosed you will find information regarding confidentiality, fees, scheduling, background information, etc. Please read this over carefully and sign/initial where highlighted. Should you have any questions, please do not hesitate to ask. Also, feel free to like and follow our Facebook Page "Let's Conquer This" where you'll find articles and information relevant to sessions.

-Alyssa Beer, LCSW, CFRC
Licensed Clinical Social Worker, Certified First Responder Counselor

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How did you hear about me?

_____

Limits to Confidentiality:
The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years.
4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and #4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name. If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Legal Rights:
I will not act as a mediator in a court situation regarding family law, to determine custody, or to aid in using therapy as a means to "win" in court. I will only attend court with a court order or a subpoena. Requested letters or reports to the court will be charged at the rates on page 3. I will also charge you this for writing reports for any medical claim such as disability. Please understand that reviewing files and writing reports takes a substantial amount of my time because I am thorough. However, this is not an activity that I am able to bill your insurance company for. The time I spend outside of one session is time I could be devoting to another person in session.

Signature agreeing to this page: _____ ***Date:*** _____

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Confidentiality and Emergency Situations:
I will not approach you in public and will not accept any friend requests or contact through social media. Appointments are scheduled with your availability and my availability kept in mind. There are times where you will have questions that you will want answered in between sessions. Please wait for your next session to have these addressed if at all possible. If you are needing to reschedule please allow me 24 hours to give the session to someone else that may need that time. If an **emergency situation** for which the client or their guardian feels immediate attention is necessary, please proceed to Millcreek Community Hospital (for children and adolescents or adults), Saint Vincent Hospital (adults only), or **Contact Crisis Services at 814-456-2014** or call 911. Understand that I am not on call and should not be the only person used when there is a crisis.

Missed Session:
You will be charged the contracted rate with your insurance company, or $110, whichever is higher. This fee will be charged to your card on file immediately. Should your card be declined, I will not be able to reschedule this appointment until the fee is paid. Please understand that I typically have a waiting list and my time is valuable.

Consent to use the Online Portal:
I use an online portal called Jituzu that is linked with my electronic records in My Clients Plus. Jituzu is designed to improve communication. Should you choose to utilize this free service, once you are registered as a client, Jituzu allows you to schedule your own appointments, make credit card payments for services, update your information, send HIPPA compliant emails and send appointment reminders. If you forget your password, you may request another one through Jituzu by clicking on the "Forgot Password" link or contacting customer service. After you are finished accessing Jituzu be sure to logout and close your browser. By signing below, you acknowledge that you have read and fully understand this consent form regarding Jituzu. You understand the risks associated with online communications between you and Alyssa Beer, LCSW, and consent to the conditions outlined herein. In addition, you agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the login screen, as well as any other instructions that Alyssa Bee, LCSW may impose to communicate with patients via online communications. You understand that Alyssa Beer, LCSW is not liable for any technology related issues with Jituzu including but not limited to security breaches and alerting errors. You understand and agree with the information that you have been provided.

To have a link emailed to you to access the online program Jituzu so you are able to schedule, reschedule, and cancel your own appointments, please provide your email here:
_____

Termination of Services:
Therapy is not intended to be a lifelong endeavor, my goal is actually to work myself out of you needing me! Ideally we would successfully complete your treatment plan and mutually end our sessions. However, if you have not scheduled a session for more than 3 months I will assume that you have decided to either take a break from therapy or discontinue therapy. At that time your file will be closed. This does not mean that your file cannot be reopened should you decide to begin again. If you find yourself in that situation, please just make me aware as to what your expectations are.

Signature agreeing to this page: _____ ***Date:*** _____

Let's Conquer This, LLC
Alyssa Beer, LCSW, CFRC

Payments & Fee Agreement:

- Returned Check Fee: $25.00
- **Canceling less than 24 hours: $50.00, unless you reschedule during the same week**
- **No-show: you will be charged the contracted rate with your insurance company, or $110, whichever is higher**
    - **This fee will be charged to your card on file immediately. Should your card be declined, I will not be able to reschedule this appointment until the fee is paid.**
- Initial evaluation (no insurance): $100.00
- Individual/Family Therapy (with no insurance): $75.00/$150.00
- Court Report and/or Evaluation Fee: $200.00/hour of preparation
- Court Appearance Fee: $200.00 per hour (fee of $200.00 still applies if notice is not given or is canceled without 48 hour notice)
- Phone/Emails: $25.00 per 15 minutes
- Attorney or provider meeting (either in person or via phone): $100.00 per hour or $25.00 per 15 minute increments
- GAL meeting, phone calls, emails: no charge
- Your insurance company will be billed if you provide an accepted insurance. If you do not have insurance you will be expected to make the payment AT THE TIME OF YOUR SESSION. I will not attend any court hearing without payment made and a court order/summons.
- You must update any insurance and/or address changes at the time of the change. If your insurance payment is denied then you are responsible for the payment of services in full.

Credit/Debit Card Authorization:

I _____ authorize Let's Conquer This, LLC/Alyssa Beer, LCSW to charge my credit/debit card indicated below for payment of services accrued on my account. These charges include fees for sessions, co-pays, cancellations/no-shows, court appearances, court reports, materials borrowed (such as books), etc. if applicable. I understand that I will be provided with regular monthly invoices for any fees I am charged with. However, should these fees not be paid after a period of 60 days, I authorize the below card to be charged in the full amount due.

Account Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Cardholder Name: _____ Account Number: _____

Expiration Date: _____ CVV code on back: _____

Billing Address: _____ City, State, Zip: _____

Phone Number: _____ Email: _____

This payment authorization is for any unpaid balance after a period of 60 days of non-payment. By signing this, I certify that I am an authorized user of this card and I will not dispute any payments made to Let's Conquer This, LLC/Alyssa Beer, LCSW, CFRC provided the transactions correspond with the amount indicated on the invoices I have been sent. I authorize Let's Conquer This, LLC/Alyssa Beer, LCSW, CFRC to charge the above card according to the terms listed above. I understand this authorization will remain in effect until I cancel it in writing. I agree to notify Let's Conquer This, LLC/Alyssa Beer, LCSW, CFRC in writing of any changes in the above account or cancellation of authorization at least 30 days prior to any changes or authorization.

Signature agreeing to this page: _____ ***Date:*** _____

Let's Conquer This, LLC
Alyssa Beer, LCSW, CFRC

Basic & Health Information:

Other providers you are working with and reason:

Provider/Agency name:	Type of Services:	Phone:

Medications:

Name of Medication:	Dosage:	Reason for Taking:	Prescribed By:	How Long on This?

Information required to bill your insurance:

Client name: _____ _____ _____ _____

(First name) (Last name) (Birthdate) (Social Security #)

Parent/Guardian (if under 18): _____

Client Address: _____

(Street) (City) (State) (Zip)

Preferred Phone: _____ Is it ok to text you appointment reminders? ___ yes ___ no

Primary Insurance Carrier Name: _____

ID #: _____ Group #: _____

Secondary Insurance Carrier Name: _____

ID #: _____ Group #: _____

Subscriber info: Name: _____ DOB: _____ Place of Employment: _____

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to the undersigned provider of supplier of services billed.

_____ _____

Patient or Authorized Person's Signature Date

Let's Conquer This, LLC
Alyssa Beer, LCSW, CFRC

Informed Consent to Provide a Minor (under the age of 14) with Therapeutic Services

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Consent for Treatment of Children/Adolescents:

I/We consent that _____ may be treated as a client by Alyssa Beer, LCSW, CFRC. It is understood that children over the age of 14 have confidentiality protected by law. Please be respectful of the need for your children to have a trusting relationship. This means that they must be able to have someone that does not come in the middle of a divorce or custody...period. Many times I see parents going through custody and divorce that have a difficult separation and it makes therapy difficult. I would like all parents to keep in mind that therapy is difficult for everyone; this includes children. If they have some confidentiality with their therapist (though it is not legally mandated) it is preferred (and will have typically better results). I will keep all parties as involved in the timeliest treatment for you and your child(ren). Please understand that if your child is 14 and over as per Mental Health Law, they are able to consent to treatment and to confidentiality. I encourage these adolescents to include and involve their parents, however if they forbid me to give you information, I am not able to legally tell you anything.
This consent to treat expires a month after the end of treatment (discharge session) or if revoked in writing.

I have brought my child _____, DOB _____, to Alyssa Beer, LCSW, CFRC, for therapeutic services. I understand that Ms. Beer's client is my child – not me, any other sibling (unless previously discussed as in the best interest of the child/children), or my spouse. This is true no matter who pays Ms. Beer for the evaluation/treatment of my child.

I understand that Ms. Beer's primary responsibility is my child's best interest and that Ms. Beer may decide to involve me in my child's evaluation/treatment at her sole discretion and this will be done in the best interest of my child. I understand that if payment is not received promptly for services rendered by Ms. Beer to my child, the services may be suspended or terminated at Ms. Beer's discretion, pursuant to the ethical guidelines governing social work and mental health care.

I understand and agree that I will not use Ms. Beer as a mediator in a court situation, to determine custody, or use therapeutic services to "win" in court in any way.

I understand that in order for my child to receive services, *both parents are required to sign this document unless a parent is proven to be unavailable or a court order prohibits orders otherwise.* If so, I will provide documentation (stating the other parent is unavailable and/or a copy of the court order) to Alyssa Beer. I have read the above paragraphs and understand them. By signing below, I agree to the above.

Mother/Legal Guardian Signature: _____ Date: _____

Father/Legal Guardian Signature: _____ Date: _____

Let's Conquer This, LLC
Alyssa Beer, LCSW, CFRC

CONSENT AND RELEASE OF LIABILITY FOR ANIMAL ASSISTED THERAPY

Bailey, a puggle hybrid (½ pug, ½ beagle) born in March of 2016, is a comfort therapy dog for Animal Assisted Therapy at Let's Conquer This, LLC. She will be in the building and available to join sessions with you upon your signed consent! She has been around small children, teens, adults, and other animals her entire life and is laid back and very friendly. She is groomed on a consistent basis and is regularly updated with shots and veterinary appointments to maintain her consistent good health.

I hope you are comfortable and find it to be beneficial to have Bailey in your sessions, as the benefits are great. However, if you are not, it is quite ok! She can be kept in a crate in another office. Therapy animals can be a vital part of treatment. Some benefits of having an animal involved in your therapy are

- The simple act of petting animals releases an automatic relaxation response.
    - Humans interacting with animals have found that petting the animal promoted the release of serotonin, prolactin and oxytocin- all hormones that can play a part in elevating moods.
- Lowers anxiety and helps people relax.
- Provides comfort.
- Reduces loneliness.
- Increases mental stimulation.
    - Assist in recall of memories and help sequence temporal events in patients with head injuries or chronic diseases such as Alzheimer's disease.
- Can provide an escape or happy distraction.
- Can act as catalysts in the therapy process.
- May help break the ice.
    - May reduce the initial resistance that might accompany therapy.

Like any other animal, Bailey's behaviors and reactions cannot be 100% predictable. Therefore, it is important for you to know the risks and rules needed to ensure both your health and safety as well as Bailey's. While I have listed some of these risks below, I cannot foresee all potential problems that may occur. Therefore, by signing this form you are releasing Alyssa Beer, LCSW, CFRC from any liability should any injury occur as part of your treatment at Let's Conquer This, LLC.

RISKS:

1. Bailey has completed 18 weeks of training to take part in Animal Assisted Therapy here at Let's Conquer This, LLC. You may opt to not have her a part of your session. Should you choose this, she will stay in her crate for the duration of your session. Please do not feel obligated to have her participate.

2. Animals have their own natural defenses. While I will do everything possible to prevent any injury, it is possible that someone will get scratched or bitten simply because she is an animal. It should be noted, Bailey has never had *any* incidents of aggression *in any manner* in the entirety of her lifetime.

3. Animals often use their mouths in play. Therefore, even when playing, it is possible for light biting to occur. When playing with a toy with Bailey, she may miss the toy and get your finger. When she realizes this, she releases and does not bite down, but you may still feel her teeth. Again, please note that she has *never* bitten anyone for any reason. There will not be any toys in sessions so Bailey is focused on you, not the toy.

4. While Bailey has been screened by a veterinarian before commencing to work as a therapy animal, animals do sometimes carry disease. Because your contact is minimal, this risk is very small. Bailey is up to date on all of her vaccinations and in excellent health.

Let's Conquer This, LLC
Alyssa Beer, LCSW, CFRC

5. If you have a history of allergic reactions with animals/dogs, it is possible you would have an allergic reaction with Bailey. Please let me know if you typically have allergies to animals.

RULES:

1. Animals have individual rights, just as each client has rights. Therefore, Bailey is allowed to determine if and when she participates with others. While it may be planned to have her in session, she will never be forced to do so.
2. Bailey has her own quiet space in the front office where she can rest, sleep, or just take a quiet break. This is separate from the therapy office. She should not be disturbed when she is in this area.
3. Bailey should always be treated gently. She should never be hit, have her tail or any other parts pulled, be carried or treated in any other way that is uncomfortable to her.
4. Bailey will always need me present in any therapeutic situation.
5. If Bailey becomes irritated, scared, or in any way acts in a negative manner, I will put her in a safe place. No other person should touch her at these times.
6. Bailey can only be utilized by myself, her therapist handler, for therapeutic sessions.
7. Because of the unpredictability of animals in unfamiliar situations, clients may not bring their own animal to be involved in their therapy session.
8. Parents or guardians of children under the age of 10 must remain on the premises during their child's session or be immediately available by cell phone.
9. Clients must wash their hands, use hand sanitizer or sanitizing wipes before and after touching Bailey.

By signing below you are agreeing that you have read this in its entirety, stating your acceptance of these rules and risks, and agree to accept full liability in the event that Bailey harms you or your child in any way in the course of treatment or you or your child is harmed in any way as a result of being on the property of 17 Merline Ave, Erie, PA 16509 or at any other place while in the presence of Alyssa Beer, LCSW, CFRC and Bailey.

Client's Printed Name **(14 and up)**	Client's Signature	Date
Parent or Legal Guardian Name	Parent or Legal Guardian's Signature	Date
Parent or Legal Guardian Name	Parent or Legal Guardian's Signature	Date

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Please sign below if you **DO NOT** want to participate or have your child participate in Animal Assisted Therapy.

Client's Printed Name **(14 and up)**	Client's Signature	Date

Let's Conquer This, LLC
Alyssa Beer, LCSW, CFRC

Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health, if necessary or chosen, with Alyssa Beer, LCSW, CFRC, as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at 814-566-0374 to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Let's Conquer This, LLC
Alyssa Beer, LCSW, CFRC

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency. In case of an emergency, my emergency contact person's name, address, phone:

Name of Emergency Person: _____

Phone: _____

Address: _____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____ _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of therapist Date