CONSENT TO ALL PRACTICE POLICIES
with
Alliance Child & Family Solutions ("ACFS")

The most recent version of ACFS Practice Policies and Forms are located at:
https://acfstexas.com/what-we-do/counseling-services/forms.html

By my signature below, I am indicating that I have verified my access and understanding of all of these forms which are considered the total "Consent to All Practice Policies."

I also acknowledge by my signature below that:

1) I have received a copy of all of the following forms:
    a) Informed Consent to Treatment & Services
    b) Privacy Policy
    c) Cancellation Policy
    d) Client Financial Responsibility Policy
    e) Court Involvement Policy
    f) Consent to Telehealth Services
    g) Consent to In-Person Services
2) I have read and understood these statements and have had ample opportunity to ask questions about, and seek clarification of anything unclear to me and have the right to ask questions of the Service Provider or Staff about any of this information at any time;
3) I voluntarily agree to receive "Services" which may include a mental health assessment, mental health care, treatment, and/or services as outlined in the Informed Consent to Treatment & Services;
4) I authorize the agency to provide such services as considered medically and ethically necessary and advisable in the provision of Services;
5) I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may at any time stop such services received through the Agency;
6) I consent to be contacted by phone call, text, and/or e-mail as needed for scheduling;
7) **I consent to the policies in each of the forms listed above and a signature on this single page is sufficient to indicate my agreement with all of these policies;**
8) I also attest that I have the right to consent to the treatment for myself or ourselves as a couple/family or of any participating dependent(s);
9) **I have answered all information in these New Client Forms and Consent to All Practice Policies to the best of my knowledge and abilities AND that I will notify the Agency within 48 hours of any change to legal information.**

I ATTEST THAT THE FOLLOWING DESCRIBES LEGAL INVOLVEMENT FOR THE CLIENT (PLEASE SELECT ONLY ONE OPTION OR YOU MAY BE ASKED TO COMPLETE THIS PAGE AGAIN):

_____ **Client is NOT named as the subject of a Court Order, Custody, Guardianship, Child Support Order, or any other Legal Decree directly indicating participation** *(note that this does not include Adult Clients who are court-ordered to pay child support as they are not considered the subject of the order but DOES include any other court orders that may be relevant to treatment for a Minor Child or Adult Client).*

_____ **Client IS named as the subject of a Court Order, Custody, or Child Support Decree**

_____ **Client is a Minor Child with two parents named on the Birth Certificate and who reside in separate homes though no Court Order, Custody, or Child Support Decree exists regarding Child.**

By my signature, I am also indicating that should this information change in the future, that I will provide any updated Court Order, Custody, or Child Support Decree within 48 hours of a hearing via the Patient Portal, fax to 817-405-3364, or email to scheduling@acfstexas.com.

CONSENT TO ALL PRACTICE POLICIES
with
Alliance Child & Family Solutions ("ACFS")

My Consent to Treatment and Services is signed, submitted, and effective as of:

_____ _____

Signature (Client/Legal Guardian) **Date**

_____ _____

Name of Client **Name of Legal Guardian** (if applicable)

***NOTE: The signatures on this form are considered valid and true regardless of whether hand-signed or signed electronically through IntakeQ, AdobeSign, DocuSign, DrChrono, OnPatient, SimplePractice, or another approved electronic venue. The signatures above / on this form also indicate that I am consenting to all of the above statements AND all Practice Policies / Forms of the Agency with my electronic signature, even if the signature does not appear on the exact lines above or at the end of each document.**

INFORMED CONSENT TO TREATMENT & SERVICES with Alliance Child & Family Solutions ("ACFS")

1. **Provision of Treatment & Services:** Alliance Child & Family Solutions (ACFS) is a 501(c)(3) nonprofit agency with the mission of providing life-changing mental health services for all of Texas.
    a. Services may include evaluation, assessment, psychotherapy, counseling, therapy, wraparound, case management, workshops, and/or presentations, referred to in full as "Services" throughout these documents.
    b. ACFS and its designated Service Provider (*credentials outlined below)* may provide these services at various locations, including but not limited to: an ACFS office location, school-based site, virtually via videoconferencing, in-home, or at a community-based agency.
    c. ACFS may offer these Services as part of a subprogram, including but not limited to these programs: Alliance Connect (*telehealth services for all ages);* Alliance Afterschool (*a partnership in select areas to provide on-site services);* Alliance at Home (*services for homebound adults and seniors)*; or Alliance Kids Care (*services for children in foster care).*
    d. Consent to Treatment & Services is valid for any ACFS program, service provider, or location.

2. **Service Providers:** ACFS may utilize employees, interns, students, subcontractors, volunteers, and/or other affiliated professionals. These individuals shall be referred to as "Service Providers" in general throughout applicable documents The ACFS Service Provider may have any of the following credentials depending on the type of Treatment or Services provided by ACFS to the Client:
    a. Full Clinical Licensure (*Licensed Clinical Social Worker ("LCSW"), Licensed Professional Counselor ("LPC"), Licensed Marriage and Family Therapist ("LMFT")*)
    b. Midlevel or Master's Level Clinicians under Supervision to be Fully Licensed (*Licensed Master Social Worker ("LMSW"), Licensed Professional Counselor –Associate ("LPC-A"/"LPC-Associate"), Licensed Marriage and Family Therapist – Associate ("LMFT-A"/"LMFT-Associate"), or Qualified Mental Health Professional ("QMHP") awaiting approval of midlevel licensure)*
    c. Graduate Practicum Student ("*Student Intern"*) in completion of a master's degree in a related field
    d. Associate or Bachelor Practicum Student in completion of a bachelor's degree in a related field (*for case management, clinical assistant, scribe, or other non-clinical direct practice services*)

    Your Service Provider will directly inform you of his/her/their credentials before initiating services. Service Providers who have not yet obtained full clinical licensure are under supervision to ensure that you receive the highest quality of service. You can direct any questions about any Service Provider to ***Anastasia Taylor, LCSW-S at 817-851-2042 x 626; stas.taylor@acfstexas.com.*** Service Providers must provide all services within the boundaries of Texas Law for Professional Counseling, Marriage and Family Counseling, and/or Social Work.

3. **Participants in Treatment & Services:** "Client" shall refer to either the sole participant or to all participants (family/couples) in Treatment and Services as a single unit as indicated by the signature(s) of all participating parties.

4. **Family/Couple Participants in Treatment & Services:** As a participant in Treatment and Services as a Family or Couple, I/we understand that during Treatment and Services, the Service Provider may request to see a smaller or larger part of the treatment unit (e.g., seeing only an individual participant of couples counseling or seeing a caregiver, parent or siblings in addition to the individual participant of counseling) for one or more sessions.

    Unless otherwise indicated, the Client should see these sessions as part of the Service Provider's work with the individual or family/couple. The Service Provider may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit to serve the treatment unit effectively. The Service Provider will use his/her/their best judgment as to whether, when, and to what extent the Service Provider must disclose information to the treatment unit. When appropriate, the Service Provider will also allow the individual or the smaller part of the treatment unit to disclose.

    Thus, if a family/couples counseling participant desires to talk about matters that he/she/they do NOT want to be shared with the other members of the treatment unit, he/she/they should consult with a Service Provider for individual Treatment and Services in addition to or in place of the family/couples counseling. If the Agency/Service Provider receives a request for records that include sessions completed as a Family/Couple, the Service Provider will seek the authorization of all members of the treatment unit before releasing confidential information to third parties.

5. **Minor Children/Legal Dependents in Treatment & Services:** The parents of minor children or guardians of legal dependents (of any age) participating in Treatment and Services must attest to the legal right and responsibility to Consent to treatment and services. **Any minor child or legal dependent who has been subject to ANY court order, custody arrangement, or legal involvement of any kind must provide evidence of such and a copy of the most recent legal decree BEFORE beginning Treatment and Services and AS UPDATED WITH THE COURT**. Service Providers are responsible for refusing, declining, or pausing services until relevant documents are on file with the Agency.

6. **After-Hour Emergencies**:
   a. If you experience a life-threatening emergency, please call 911 or go to the closest emergency room.
   b. If you have an after-hours mental health emergency, you may also contact our main number, 817-851-2042 x 1, to be connected to the National Suicide Hotline.
   c. Please call during regular business hours for non-urgent questions or concerns.

7. **Benefits to Services:** Possible benefits to Services include improved cognitive functioning, academic or job performance, health status, quality of life, and awareness of strengths and limitations. **There are no guarantees about what will happen as Services require a very active effort on the Client's part.**

8. **Risks of Services:** Choosing to participate in Services may include risks of experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness because the process of providing Services often requires discussing the unpleasant aspects of your life.

9. **Probable Consequences of Not Receiving Services:** Possible consequences of not receiving or participating fully in Services can include impairment of work activities, family relationships, or social functioning. The Service Provider will discuss specifics during Services as Client actions are proposed.

10. **Services Administration:** Services will be administered with the individual and/or family as is needed for maximum benefit, for the duration and frequency discussed at the onset of Services. The frequency of services will be dependent on payor source, Client needs, Client availability, and Service Provider or agency availability. Services may be completed in-home, provider office, school-based site, videoconferencing, telephonically, or another physical location as agreed upon by both parties and as is determined to be in the best interest of the Client receiving Services.

    Treatment modalities may include, but not be limited to Client-Centered Therapy, Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR), Family Systems, Gestalt, Motivational Interviewing, Outcomes Oriented Therapy, Play Therapy, Psychoanalytic, Rational Emotive Therapy, Solution Focused Therapy, Trauma-Focused – CBT (TF-CBT), Trust-Based Relational Intervention (TBRI), or others.

11. **Alternative Treatments:** The Service Provider may assist in recommending additional professionals who can help in this process. Alternative treatment methods may include medications or supplements as prescribed by a licensed professional, referrals to a higher level of care, and/or other therapeutic approaches that ACFS may not offer at this time or within the timeframe needed by the Client. **ACFS Service Providers cannot prescribe medications or complete a psychological evaluation under any of the licensures utilized for services at present.**

12. **Charges:** Fees are determined by the length or type of Services provided. The Client will be responsible for any costs not covered by insurance, including co-payments, co-insurance, and deductibles. Cash pay rates, no show fee amounts, additional services or charges, Financial Assistance Plan cash pay fees, group therapy fees, or any other service provided are outlined in our Fee Schedule, which is available upon request. **NO records will be released until all financial obligations are paid in full. Please see Client Financial Policy for additional details.**

13. **Confidentiality, Harm, and Inquiry:** Information from participation in Treatment and Services is contained in a confidential medical record at ACFS, and I consent to disclosure for use by the Service Provider for the purpose of continuity of care. Per Texas mental health law, the information provided will be kept confidential with the following exceptions: 1) if Client is deemed to present a danger to himself/herself or others; 2) if concerns about possible abuse or neglect arise; 3) if concerns about past impropriety or exploitation by a mental health professional; or 4) if a court order

signed by a judge is issued to obtain records in which provision of such records outweighs the risks of a treatment letter instead.

14. **Right to Withdraw Consent:** I/we have the right to withdraw my Consent for Services of myself or my legal dependent at any time by providing a written request to the Service Provider and/or ACFS.

15. **Expiration of Consent:** This Consent to treat will expire 12 months from the date of signature unless otherwise specified. Though a Client may be considered discharged from services when there is a lapse in services provided for 30 days or more, no additional consent forms shall be requested to re-initiate services as long as the consent forms are the most current copy and were executed within the last 12 months.

16. **Boundaries and Social Media: You are encouraged to follow ACFS on Social Media.**

    However, please refrain from making contact with the Agency or your Service Provider using social media systems (Facebook, Twitter, Tumblr, LinkedIn, Instagram, Pinterest, etc.). These methods have insufficient security, are not considered appropriate boundaries, nor are they closely monitored.

My Consent to Treatment and Services is signed, submitted, and effective as of:

_____ _____

Signature (Client/Legal Guardian) **Date**

_____ _____

Name of Client **Name of Legal Guardian** (if applicable)

***NOTE: The signatures on this form are considered valid and true regardless of whether hand-signed or signed electronically through IntakeQ, AdobeSign, DocuSign, DrChrono, OnPatient, SimplePractice, or another approved electronic venue. The signatures above / on this form also indicate that I am consenting to all of the above statements AND all Practice Policies / Forms of the Agency with my electronic signature, even if the signature does not appear on the exact lines above or at the end of each document.**

*****PLEASE NOTE THAT NO SIGNATURE MAY BE PRESENT ON THIS FORM. A SIGNATURE ON THE FORM "*CONSENT TO ALL PRACTICE POLICIES WITH ALLIANCE CHILD & FAMILY SOLUTIONS ("ACFS")*" IS SUFFICIENT TO INDICATE AGREEMENT TO THE POLICIES WITHIN THIS FORM*****

If you have any complaints, you may contact the Texas Behavioral Health Executive Council:

Texas Behavioral Health Executive Council **Attn: Enforcement Division** **333 Guadalupe St., Ste.3-900** **Austin, Texas 78701**	**More information can be found at:** https://www.bhec.texas.gov/discipline-and-complaints/index.html Phone: 1-800-821-3205 E-mail: Enforcement@bhec.texas.gov

PRIVACY POLICY of
Alliance Child & Family Solutions ("ACFS")

1. **Purpose of this Notice:** Alliance Child & Family Solutions ("ACFS") and its employees, interns, students, subcontractors, volunteers, and affiliated professionals ("Service Providers") respect the privacy of protected health information and understands the importance of keeping this information confidential and secure.

   This Notice describes how we protect the confidentiality of the protected health information we receive. HIPAA refers to the Health Insurance Portability and Accountability Act of 1996. ACFS maintains a process to ensure compliance with applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Since our goal is to provide the highest level of service to our clients and business partners, we want you to know how ACFS complies with the HIPAA directives. Our HIPAA Privacy Policy contains procedures addressing the protection, use, and disclosure of protected health information ("PHI"); accounting of disclosures, access by individuals and third parties to PHI; protection of PHI by contractors; use of business associate agreements; and training of Service Providers. The following privacy policy is adopted to ensure that this practice complies fully with all federal and state privacy protection laws and regulations. Protection of Client privacy is of paramount importance to ACFS.

2. **Publication of this Notice:** It is the policy of ACFS that a notice of privacy practices must be published, that this Notice is provided to all subject individuals at the first Client encounter if possible, and that all uses and disclosures of protected health information be done in accord with ACFS's Notice of privacy practices. It is the policy of ACFS to post the most current Notice of privacy practices on our website and to have copies available for distribution with our on-site clinicians.

3. **How We Protect Personal Information**: We treat personal information securely and confidentially. We limit access to personal information to only those persons who need to know that information to provide support services to our clients. These persons are trained on the importance of safeguarding this information and must comply with our procedures and applicable laws. We employ strict physical, electronic, and procedural security standards to protect personal information and maintain internal procedures to promote the integrity and accuracy of that information. All records are electronic and maintained/stored by ACFS and not by individual Providers within ACFS. If for any reason a Provider is incapacitated or no longer employed with ACFS, the Client will be provided the option to transfer to another provider and/or given external referrals if needed.

4. **Disclosure of Personal Information**: There are several circumstances in which disclosure of personal or protected health information may be voluntary, and other times when the nature of our services requires involuntary disclosures of this information when applicable to the circumstances described below:
   a. We may use or disclose personal or protected health information during the course of clinical research activities, but this would be with the written consent of the Client prior to beginning any clinical research activities.
   b. Service Providers are considered mandatory reporters in the occurrence of abuse/neglect. As such, we may disclose personal or protected health information to the appropriate authorities, as is required by law, in instances in which there is a reasonable suspicion that the Client and/or his/her/their immediate family has been the victim of abuse, neglect or domestic violence.
   c. In the case of a minor child(ren) or legal dependent(s) participating in individual Services, the ACFS Service Provider will seek to disclose the minimum amount of information necessary to Parents and/or Legal Guardians to preserve the therapeutic alliance between the Service Provider and Client. The Service Provider will disclose concerns about the Client's safety, especially in situations requiring increased supervision or a higher level of care, or in cases in which the Service Provider deems such disclosures necessary to aid in parent coaching or training to support the Client's needs.
   d. Please see Section 4, Paragraphs 2 and 3, of the "Informed Consent to Treatment & Services" for detailed information about how ACFS handles disclosures of personal information of participants in family/couple counseling.

5. **Individual Rights to Access and Correct Personal Information**: We have procedures in place for individuals to have access to protected health information and procedures in place to ensure the integrity of our information and for the timely correction of incorrect information. **Records will not be released to outside approved entities until any/all financial responsibilities are paid in full by the Client.**

6. **Minimum Necessary Use and Disclosure of Protected Health Information:** It is the policy of ACFS that for all routine and recurring uses and disclosures of PHI (except for uses or disclosures made 1) for treatment purposes, 2) to or as authorized by the Client or 3) as required by law for HIPAA compliance such uses and disclosures of protected health information must be limited to the minimum amount of information needed to accomplish the purpose of the use or disclosure. It is also the policy of ACFS that non-routine uses and disclosures will be handled pursuant to established criteria. It is also the policy of ACFS that all requests for protected health information (except as specified above) must be limited to the minimum amount of information needed to accomplish the purpose of the request.

7. **Deceased Individuals:** It is the policy of ACFS that privacy protections extend to information concerning deceased individuals.

8. **Training and Awareness**: It is the policy of ACFS that all Service Providers have received information, been trained on the policies and procedures governing protected health information, and trained on how ACFS complies with the HIPAA Privacy and Security Rules. It is also the policy of ACFS that Service Providers sign a written commitment to follow these policies and procedures upon joining ACFS's workforce. It is the policy of ACFS to provide training should any policy or procedure related to the HIPAA Privacy and Security Rule materially change. This training will be provided within a reasonable time after the policy or procedure materially changes. Furthermore, it is the policy of ACFS that training will be documented, indicating participants, date, and subject matter.

9. **Further Information:** ACFS may find it necessary to revise and update its HIPAA Privacy Policy from time to time as changes to the privacy regulations emerge and will communicate any such changes to our clients and business partners.

10. **Rights:** As a Client receiving services from an ACFS Service Provider, clients have the right to:
    a. Understand and use these rights. If for any reason, a Client does not understand or need help, ACFS must provide assistance.
    b. Receive services without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, or source of payment.
    c. Be treated with courtesy and respect throughout the course of all services provided.
    d. Be informed of the name, position, and credentials of the Service Provider who will assist the Client.
    e. Refuse services at the discretion of the Client.
    f. Understand that Service Providers prefer a smoke-free environment, and smoking during the visit is prohibited.
    g. Receive all information needed for the Client to give Informed Consent to proposed Treatment and Services.
    h. Receive an explanation of all incurred charges upon request.
    i. Complain without fear of reprisals about the services received and have ACFS respond in a timely manner. If the Client is not satisfied with ACFS's response, he/she/they may request information regarding how to obtain another Service Provider or external referrals to an outside entity.
    j. Receive a reasonable response to any reasonable request for services from ACFS.

11. **For Treatment:** Service Providers may review and record information in a Client's record about the services, treatment, and care provided by Service Providers. We will use and disclose this health information in order to provide the best treatment and care for our clients. For example, a therapist may consult with another therapist regarding how to best provide treatment in a specific Client scenario.

12. **For Payment:** Our ACFS may use and disclose PHI to others for ACFS to bill for health care services or mental health treatment in order to receive payment. For example, we may include health information in our claim to a Client's insurance company, Medicare, or Medicaid to receive payment for services provided. We may also disclose personal or health information to other providers so that they can receive payment for the services provided. We may also use the minimum identifying information necessary to report services received through grant-funded programs.

This Policy is signed, submitted, and effective as of:

Signature (Client/Legal Guardian)	**Date**
Name of Client	**Name of Legal Guardian** (if applicable)

***NOTE: The signatures on this form are considered valid and true regardless of whether hand-signed or signed electronically through IntakeQ, AdobeSign, DocuSign, DrChrono, OnPatient, SimplePractice, or another approved electronic venue. The signatures above / on this form also indicate that I am consenting to all of the above statements AND all Practice Policies / Forms of the Agency with my electronic signature, even if the signature does not appear on the exact lines above or at the end of each document.**

*****PLEASE NOTE THAT NO SIGNATURE MAY BE PRESENT ON THIS FORM. A SIGNATURE ON THE FORM "*CONSENT TO ALL PRACTICE POLICIES WITH ALLIANCE CHILD & FAMILY SOLUTIONS ("ACFS")*" IS SUFFICIENT TO INDICATE AGREEMENT TO THE POLICIES WITHIN THIS FORM*****

CANCELLATION POLICY of
Alliance Child & Family Solutions ("ACFS")

1. **Purpose of Notice:** To see our clients as efficiently as possible and avoid wait time for you, we do not overbook time slots for Treatment or Services. When an appointment is made, it prevents other Clients from receiving services with one of our Service Providers during that time. Please be advised of the following fees AND scheduling policies.

2. **Amount of Fee:** The cash pay price of your Service Provider will be assessed for each No Show or Late Cancellation *(when less than 24 hours notice is given prior to the cancellation request)*.
   a. **FEE OF $125.00** for Service Providers with Full Clinical License – LCSW, LPC, LMFT
   b. **FEE OF $85.00** for Midlevel Service Providers – LMSW, LPC- Associate/Intern, LMFT-Associate, QMHP
   c. **FEE OF $35.00** for Graduate Practicum Student
   d. NO FEE for Bachelors Practicum Students

   Please understand that insurance companies consider this charge to be entirely the Client's responsibility, and you will not be contacted by our Billing Department prior to your card being charged for missing or late cancellation of a scheduled appointment.

3. **Types of Changes to Scheduled Appointments:**
   a. **No Show:** A "no show" is missing a scheduled appointment. – **YOU WILL BE CHARGED A FEE.**
   b. **Late Cancellation:** A "late cancellation" is any cancellation less than 24 hours from your scheduled appointment time. – **YOU WILL BE CHARGED A FEE.**
   c. **Cancellation of Appointment due to Failure to Abide by ACFS Policies:** This cancellation is related to times in which the Client is present for the scheduled appointment, but the ACFS Service Provider must end the session due to failure of the Client to abide by policies. Such instances may include, but are not limited to the following scenarios:
      - Client arrives significantly late to session and the remaining time is insufficient to conduct Services;
      - Client fails to submit required court paperwork prior to the start of the session;
      - Client fails to resolve billing issues; and/or
      - **Client attempts to begin their telehealth session while in a public place or with others in the room**.
      - Though the Client was present for the session, this cancellation is at the error of the Client. – **YOU WILL BE CHARGED A FEE**
   d. **Cancellation:** Regular cancellations are appointments that are scheduled but are changed with at least 24 hours' notice or more in advance. This is still considered an unplanned change, but NO FEE assessed.

4. **Exceptions**: We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept, and adequate notice is not possible. **These situations will be considered on a case-by-case basis.** While we do our best to send reminders ahead of the appointment, **it is the Client's responsibility to be aware of any appointments scheduled with the Service Provider**. The Client may still be assessed financial penalties for a missed session even if the Client did not receive a reminder call, text, or e-mail in advance.

5. **Where to Cancel**:
   a. **You should message your Service Provider directly through the Client Portal as soon as you become aware that you will miss an appointment, even if it is less than 24 hours before your appointment.**
   b. As soon as you are aware you cannot attend your appointment, you can also call our office at 817-851-2042 and listen to the voice prompts to be directed to the right option as an established Client.
      i. Please be aware that phones may not be answered at the time of your call due to limited staffing.
      ii. If you call and someone is not available to take your call, you must still leave a detailed message or e-mail to possibly avoid financial penalties.
   c. You can also provide written cancellation via e-mail to **scheduling@acfstexas.com**.

6. **Recurring Appointment & Cancellations:** Our Service Providers and Staff work in conjunction to provide you with a convenient time for you to attend your appointments on an ongoing basis. For this reason, multiple cancellations, even with advanced notice, can leave our therapists with open spots yet without allowing additional clients to be seen.
   a. **Two Unplanned Changes:** A combination of two no shows, cancellations (*even with sufficient notice*), or late cancellations within a short period of time can lead to your scheduled spot being provided to another client, especially if during the hours of 3 – 8 pm or on the weekend, as these times are in high demand.
   b. **Three Unplanned Changes:** This can lead to being referred to another practice at the discretion of the Service Provider or Staff, depending on the circumstances.

CANCELLATION POLICY of
Alliance Child & Family Solutions ("ACFS")

This Policy is signed, submitted, and effective as of:

_____ _____

Signature (Client/Legal Guardian) **Date**

_____ _____

Name of Client **Name of Legal Guardian** (if applicable)

***NOTE: The signatures on this form are considered valid and true regardless of whether hand-signed or signed electronically through IntakeQ, AdobeSign, DocuSign, DrChrono, OnPatient, SimplePractice, or another approved electronic venue. The signatures above / on this form also indicate that I am consenting to all of the above statements AND all Practice Policies / Forms of the Agency with my electronic signature, even if the signature does not appear on the exact lines above or at the end of each document.**

*****PLEASE NOTE THAT NO SIGNATURE MAY BE PRESENT ON THIS FORM. A SIGNATURE ON THE FORM "*CONSENT TO ALL PRACTICE POLICIES WITH ALLIANCE CHILD & FAMILY SOLUTIONS ("ACFS")*" IS SUFFICIENT TO INDICATE AGREEMENT TO THE POLICIES WITHIN THIS FORM*****

CLIENT FINANCIAL RESPONSIBILITY POLICY of Alliance Child & Family Solutions ("ACFS")

1. **Purpose of this Policy:** It is important that you understand the following values of ACFS:
   a. As your Service Provider, our relationship is with you, not your insurance company.
   b. In efforts to be accountable and fiscally responsible for the good of all of our Clients, we must ensure that all fees are paid in full within 24 hours of receiving services.
   c. Service Providers are responsible for refusing, declining, or pausing services until all fees are paid in full and/or alternate payment arrangements are made directly with the Billing Department.

2. **Insurance:**
   a. **It is your responsibility as the Client to know your benefits**; you will NOT be called in advance of your appointment regarding verification of benefits. We encourage you to contact your insurance company so you can be informed of any copays, fees, deductibles, or limitations with your insurance plan.
   b. As a courtesy, we attempt to verify benefits and file claims to your insurance at no charge. Insurance payments are to be made directly to the agency.
   c. If we have an agreement with your insurance company, we will honor the rates, co-payments, co-insurances, and deductibles defined in our agreement. You are responsible for all co-payments, deductibles, and non-covered charges on the day of your service.
   d. It is your responsibility to keep ACFS up to date with your correct insurance information. **If the insurance company you designate is incorrect or you have not updated your Coordination of Benefits information with your insurance company, you will be responsible for payment for the visit at the cash pay rate of $150/Initial Visit or $135/Follow-Up Visit.**
   e. Please always feel free to contact our Billing Department with any concerns, questions, or information regarding your account at 817-851-2042 x 888 or billing@acfstexas.com.

1. **Credit Card Storage & Usage:**
   a. **We require all Clients to place a confidential payment method on file** (credit card, HSA, or checking account) to manage collection of co-payments, deductibles, co-insurance, or no show/late cancellation fees.
   b. Payment information stored in a secure, encrypted system that complies with Payment Card Industry Data Security Standard.
   c. Payment information can also be updated via the Patient Portal.
   d. Any individual with access to the payment portion of our systems can only see the last 4 digits of your payment method and are unable to transfer the information between systems.
   e. If you do not have insurance, choose not to utilize your insurance for services, or have a high deductible, you are expected to pay all fees at the time of service.

2. **Payment Processing**
   a. **We use a variety of payment systems depending on the Service Provider and Services being received. Payment Receipts are sent via email and may be sent from any of the following systems: DrChrono, ClearGage, SimplePractice, IntakeQ, Square, Stripe, Venmo, or PayPal.**
   b. Payment Receipts may also list Anastasia Taylor on receipts, even if you are receiving services from a different Service Provider.
   c. Our Billing Department will automatically bill your account for recurring visits with established co-payments, co-insurance, and/or late cancellation or no show fees without calling in advance.
   d. Once ACFS receives payment from your insurance company, the Billing Department may bill your account automatically for any fees not covered by your insurance, including deductibles and copayments or differences between the estimated costs and actual fees for service.
      - ACFS does not control the speed at which insurance companies process said claims or the length of time afterwards in which an insurance company may recoup funds.
      - The Client is still responsible for these fees regardless of length of time.

3. **Financial Assistance Options:**
   a. **CASH PAY BY PROVIDER LEVEL**: As a Cash Pay client, there are no requirements to take advantage of these plans. If interested, select the level of Service Provider for services when scheduling your visit:
      - Masters-Level Practicum Students = $50/Initial Visit + $35/Follow Up Visits
      - Midlevel Providers (LMFT-A, LMSW, LPC-Associate) = $100/Initial + $85/Follow Up Visits
      - Clinical Therapist (LCSW, LMFT, and LPC) = $150/Initial Visit + $135/Follow Up Visits
      - Rates are subject to change at any time though the Agency will seek to provide at least 14 days notice of any change in rates.
   b. **REDUCED FEES BASED ON INCOME:** Fees may be eligible to be reduced upon completion of the "Financial Assistance Plan Application" along with supporting documents (proof of income).
      - This application is processed in-house as a courtesy to our clients who may be facing financial difficulties in paying for their services.
      - We do not check your credit when determining if you are eligible for a lowered discount from our Cash Pay fees.
      - Insurance cannot be utilized for services if the copay or deductible is the amount being reduced.
   c. **GRANT-FUNDED PROGRAMS:** At various times, we may have grant-funded programs that offer services for low to no-charge for qualifying participants. Inquire with our Billing and Scheduling Department for current program offerings and eligibility information.

4. **Other Charges or Fees**
   a. **Letters** (including Treatment Summaries, Emotional Support Animals, IEP Recommendations, etc.) may be assessed an additional fee of $50.00 to be paid prior to receiving written documentation.
      - **Please allow 48 business hours from the time of payment to draft and submit requested documentation. These items can generally NOT be provided same day.**
   b. **Court Involvement** (see our Court Involvement for more information about fees and services)
      - **Subpoenas should be received as far in advance as possible, though at least two weeks' notice is preferred.**
      - **Subpoenas for records must be requested directly from a judge due to HIPAA regulations to protect PHI.**
      - **Assuming all requirements are met, Court Involvement Fees for records or appearance must be paid in full by the requesting party at least 48 hours prior to the appearance.**

By my signature below, I am indicating that I have read and understand all of the above, have had an opportunity to ask questions about this information, and I consent to this Policy as part of my Services and Treatment.

I also acknowledge by my signature below that:

1. I authorize Alliance Child & Family Solutions ("ACFS") to keep my signature on file and to charge my account for:
   a. Balances of charges not to exceed $150.00 per claim for: clean claims with balances for co-insurances and deductibles which are reflected on your explanation of benefits.
   b. Recurring charges for ongoing treatments with established co-payments, co-insurance, and/or any late and/or no-show fees.
2. I assign my insurance benefits to the practice listed above (ACFS). I understand that this form is valid for five (5) years unless I cancel the authorization through written notice to the health care provider.
3. I understand I must notify the practice of any card renewals, insurance changes, or other account changes.
4. I have read and understood these statements and have had ample opportunity to ask questions about the information and seek clarification of anything unclear to me.

This Policy is signed, submitted, and effective as of:

_____	_____
Signature (Client/Legal Guardian)	**Date**
_____	_____
Name of Client	**Name of Legal Guardian** (if applicable)

***NOTE: The signatures on this form are considered valid and true regardless of whether hand-signed or signed electronically through IntakeQ, AdobeSign, DocuSign, DrChrono, OnPatient, SimplePractice, or another approved electronic venue. The signatures above / on this form also indicate that I am consenting to all of the above statements AND all Practice Policies / Forms of the Agency with my electronic signature, even if the signature does not appear on the exact lines above or at the end of each document.**

*****PLEASE NOTE THAT NO SIGNATURE MAY BE PRESENT ON THIS FORM. A SIGNATURE ON THE FORM "*CONSENT TO ALL PRACTICE POLICIES WITH ALLIANCE CHILD & FAMILY SOLUTIONS ("ACFS")*" IS SUFFICIENT TO INDICATE AGREEMENT TO THE POLICIES WITHIN THIS FORM*****

COURT INVOLVEMENT POLICY of Alliance Child & Family Solutions ("ACFS")

THIS FORM IS STANDARD FOR ALL CLIENTS TO BE AWARE OF OUR POLICIES, EVEN IF NOT PERTAINING TO YOUR UNIQUE SITUATION. PLEASE STILL READ IN FULL & SIGN.

1. **Purpose of Policy:** The parents of minor children or guardians of legal dependents (of any age) participating in Treatment and Services must attest to the legal right and responsibility to Consent to treatment and services.

2. **Relevant Court Orders**: All instances in which there are court documents related to divorce involving a minor child, associated custody agreements, guardianship paperwork, official paperwork related to the ability to consent to psychotherapy treatment, and/or any past or currently open court filings regarding a minor child MUST be disclosed and submitted in full to our agency.

    a. **Any minor child or legal dependent who has been subject to ANY court order, custody arrangement, or legal involvement of any kind must provide evidence of such and a copy of the most recent legal decree BEFORE beginning Treatment and Services and AS UPDATED WITH THE COURT**.
    b. Paperwork can be submitted via the Patient Portal, fax (817-405-3364), or e-mail (scheduling@acfstexas.com) so this information can be reviewed and uploaded to the chart in advance of the appointment.
    c. **Service Providers are responsible for refusing, declining, or pausing services until relevant documents are on file with the Agency.**
    d. The Agency and/or Service Provider reserves the right to immediately terminate all services in any situation in which the Agency or Service Provider believes that the Client, Parent, and/or Legal Guardian intentionally lied or omitted information regarding the existence of court orders.

3. **Legal Consent to Treatment:** In (most) cases involving minor child(ren), the Guardian initiating the request for Services and Treatment will be asked to provide the contact information of the other parent in order for both to consent to treatment.
    a. Each parent and/or legal guardian with authority over the health care decisions of the child, will agree to these terms and communicate effectively with each other as well as with the provider to create a supportive environment for treatment and to assist our clinicians toward attempting to achieve the most positive outcome possible.
    b. Even if a single guardian has the sole right to consent to treatment, the Agency will make all efforts for the second parent to be informed of and consent to Services except in the following circumstances:
        i. The Court specifically prohibits such involvement,
        ii. The Other Parent or Second Guardian is deceased, or
        iii. The Guardian initiating the request for Services and Treatment is willing to notarize that they do not have any contact information to the other Guardian.

4. **Involvement by Parents:** As children are part of a family system, decisions about psychological, medical, and/or educational care, etc. must be made by the child's legal guardian(s).
    a. **Legal guardian(s) of any minor child receiving Services from ACFS must be physically present at the first visit to provide consent, have an opportunity to be fully informed of the treatment process, be provided with an opportunity to ask questions, and in order for identity to be verified.**
    b. Both parents are invited and encouraged (as they are able) to participate in the process of treatment.
    c. Both parents, regardless of custody, have a legal right to information unless otherwise indicated in a court order.

    Although our responsibility to your child may require our involvement in conflicts between parents and guardians, we need your agreement that our involvement will be strictly limited to that which will benefit your child. This means, that you each agree as a condition of us treating your child that:
    a. You shall treat anything that is said in any individual, group, or family therapy session as strictly confidential;
    b. Our role is limited to providing Treatment and Services. You shall not attempt to gain advantage in any legal proceeding relating to the care and custody of your child from our Treatment and Services of your child;

c. You shall not request or require us, through subpoena, summons or other means (except as otherwise ordered by a court of competent jurisdiction), to provide testimony in favor of one parent or guardian against the other in any legal proceeding relating to the care and custody of your child; and
d. If multiple parents or guardians desire to obtain treatment information and/or testimony from any one of our clinicians relating to your child in any legal proceeding you shall each consent to the disclosure by executing one or more authorization forms we send to you and you will each share in the cost of producing such records and/or written or live testimony at our established copying charges and/or hourly rates for our clinician's time.

5. **Communication to Service Providers:** For HIPAA reasons, ALL communication to the Service Provider must be sent through the Patient Portal:.
   a. All messages to/from the Service Provider will be visible to all parties and that ANY records requested must be requested by both parties and discussed with the Minor Child before record will be released.
   b. In instances in which the system limitations require both Guardians to utilized a shared login, both Guardians agree not to change the login or password information to the Patient Portal unless both parties have notified in advance in writing.

6. **Mental Health Treatment with Families in Conflict:** As a mental health treatment practice our primary focus, responsibility and goal is the treatment and well-being of our identified patients. In the case of a child as the primary patient it is essential that parents and legal guardians are not in conflict and are in fact in agreement as to decision to treat, the treatment goals, appointment times and the need to maintain patient confidentiality. The therapeutic process is a team approach, especially in the case of a minor child.

7. **Coverage of Fees**: For Treatment or Services in which a court order specifies payment responsibility between two legal guardians: As a courtesy to the parents at their request, the Billing Department will split the patient responsibility of the patient portion to be collected at the time of service between each parent when both cards are on file.
   a. Should one of the two legal guardians be unwilling or unable to put a card on file despite court orders indicating responsibility of payment, the minor cannot continue to be seen for treatment unless all client responsibilities are paid in full.
   b. If too many issues arise with the collection process, the Billing Manager can decide at any time to stop collecting fees between parents and parents would need to decide who will pay as the primary and seek reimbursement from the other parent.

8. **Court Involvement After the Onset of Treatment**: Since the client-therapist relationship is built on trust with the foundation of that trust being confidentiality, it is often damaging to the therapeutic relationship for the therapist to be asked to present records to the court, testify whether factual or in an expert nature, in court or disposition. The therapist asks that clients only request a court appearance in extreme cases. Court appearances or involvement after the onset of treatment could result in the need to terminate therapy and refer you to another practice.

9. **Limits of Treatment:** Our Services and Treatment can NOT at any time:
   a. Determine if a traumatic incident truly occurred.
   b. Determine what parent is a better placement.
   c. Be used in lieu of a social study to evaluate household environment
   d. Guarantee participation of the Agency or Service Provider to complete disability paperwork or make recommendations for Emotional Support Animals.

10. **Fees for Court Appearances, Letters, and Other Paperwork**
    a. Court appearances are billed at two hundred dollars ($200.00) per hour with a minimum charge of eight (8) hours, for a total of one thousand six hundred dollars ($1,600.00). Should the total time of the provider take less than 8 hours, the difference will NOT be refunded. However, time exceeding 8 hours of work WILL be billed to the appropriate party on a per quarter hour basis.
    b. Testimony before any court, arbitrator, mediator, or other hearing officer are billed at two hundred dollars ($200.00) per hour with a minimum charge of eight (8) hours, for a total of one thousand six hundred dollars ($1,600.00). This may include any and all circumstances in which it is necessary for the therapist to testify before any court, arbitrator, or other hearing officer to testify at a deposition, whether the testimony is factual or expert, or to present any or all records pertaining to the counseling relationship to a court official.

c. Requests for involvement by phone to any attorney, court, arbitrator, mediator, or other hearing officer billed at two hundred dollars ($200.00) per hour and will only be completed if a credit card is on file and written consent / request by the Client is made in writing in advance.
d. The client agrees to pay the therapist for his or her services, including travel, preparation, and necessary expenditures at the rate of two hundred dollars ($200.00) per hour, rounded to the nearest half hour, with a minimum charge of eight (8) hours, for a total of one thousand six hundred dollars ($1,600.00). These expenditures include, but are not limited to copies, parking, meals, and the like.
e. The client agrees to pay the one thousand six hundred dollars ($1,600.00) minimum fee at least two weeks prior to the appearance, presentation of records, or testimony requested. All additional expenditures will be billed after the court appearance.
f. Other letters and paperwork requested by the client will be assessed a charge of fifty dollars ($50.00) per hour, rounded to the nearest hour, with a minimum 1 hour charge. This does include letters to court officials or attorneys, short-term disability paperwork, and any other documentation requested by the client. This does not include copies of your bill, missed work or school letters, release of information forms, nor any other documents used in the day-to-day operation of the office. It is the responsibility of ACFS to alert you of any additional charges assessed at the time of the client request.
g. Charges assessed to Client are separate from fees allotted to Providers; this will be handled internally.

11. **Insurance in Court Involved Cases:** Because of the possibility of significant legal involvement and additional fees, it is the policy of ACFS to accept Commercial Insurance Only (*no Medicare, Medicaid, or Managed Medicaid Plans*) for court-ordered treatment. **Clients who are court-ordered to treatment or become involved with the court system who have Medicare, Medicaid, or Managed Medicaid Plans as their primary or secondary forms of insurance will be immediately either converted to become a cash pay client or discharged from the practice upon the first No Show or Late Cancels for any reason.**

By my signature below, I am indicating that I have read and understand all of the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I understand that I have the right to ask questions of the Therapist about the above information at any time. I also acknowledge by my signature below that:

1. I also attest that I have the right to consent to the treatment for myself or ourselves as a couple/family or of any participating minor client(s),
2. I have submitted copies of any relevant court paperwork regarding the ability to consent to mental health treatment,
3. I voluntarily agree to receive mental health assessment and mental health care, treatment, and/or services, and I authorize the agency to provide such services as considered necessary and advisable,
4. I understand that as the custodial parent of the minor child, I am responsible for any and all payments due. Any payment received from the minor child's other parent, guardian, or family member will be deducted and applied appropriately to the child's account. If the account is in default or a payment has not been made, ACFS will look to me as the sole party responsible for the financial obligations of the account.
5. I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may at any time stop such services received through the agency, and
6. I have read and understood these statements and have had ample opportunity to ask questions about, and seek clarification of anything unclear to me.

This Policy is signed, submitted, and effective as of:

Signature (Client/Legal Guardian)	**Date**
Name of Client	**Name of Legal Guardian** (if applicable)

***NOTE: The signatures on this form are considered valid and true regardless of whether hand-signed or signed electronically through IntakeQ, AdobeSign, DocuSign, DrChrono, OnPatient, SimplePractice, or another approved electronic venue. The signatures above / on this form also indicate that I am consenting to all of the above statements AND all Practice Policies / Forms of the Agency with my electronic signature, even if the signature does not appear on the exact lines above or at the end of each document.**

*****PLEASE NOTE THAT NO SIGNATURE MAY BE PRESENT ON THIS FORM. A SIGNATURE ON THE FORM "*CONSENT TO ALL PRACTICE POLICIES WITH ALLIANCE CHILD & FAMILY SOLUTIONS ("ACFS")*" IS SUFFICIENT TO INDICATE AGREEMENT TO THE POLICIES WITHIN THIS FORM*****

CONSENT TO TELEHEALTH SERVICES of Alliance Child & Family Solutions ("ACFS")

1. **Provision of Telehealth Services:** This document covers your rights, risks and benefits associated with receiving services via Telehealth.

2. **Telehealth Services Defined:** Telehealth Services means the remote delivering of psychotherapy health care services via technology-assisted media. This includes a wide array of clinical services and various forms of technology. The technology includes but is not limited to video, internet, a smartphone, tablet, PC desktop system or other electronic means. The delivery method must be secured by two-way encryption to be considered secure. Synchronous (at the same time) secure video chatting is the preferred method of service delivery as many insurances will not cover communication solely by phone, text, or e-mail.

3. **Interactive Video, Electronic Medical Record, Secure Email for Documents:** ACFS currently utilizes several platforms for interactive video. Any platform utilized will meet the following security guidelines: no patient info is stored persistently; all data is encrypted using the AES cipher with 128-bit keys to encrypt audio/video; and HMAC-SHA1 to verify data integrity; HIPAA, PIPEDA, and GDPR data privacy requirements.

4. **Client Responsibilities for Telehealth Therapy Services:** The Service Provider will also verify your location at the start of each session after your identity has been confirmed.
   a. **Virtual sessions can only be conducted while the client is physically located within the state of Texas.**
   b. The virtual sessions must be conducted on a Wi-Fi connection for the best connections and to minimize disruption. We strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g. has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.) Do not use "auto-remember" names and passwords.
   c. Make sure you have checked your company's policy before using a work computer for personal communication. As the client, you are responsible for finding a private, quiet location where the sessions may be conducted. Consider using a "do not disturb" sign/note.
   d. **Sessions are not able to take place if other individuals are present in your location who have not previously signed a Release of Information or forms consenting to treatment as a group.** This includes that the Client must **NOT** initiate telehealth services while in a public place. **ACFS Service Provider reserves the right to cancel the session in these instances and the Client may be assessed the No Show Fee.**

5. **In Case of Technology Failure:** It is possible that during a Telehealth session there could be a technological failure; difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions.
   a. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, please message the provider through the Client Portal.
   b. The Service Provider may attempt to reach you by phone to discuss other options to complete the visit, such as rescheduling the visit if there are problems with connectivity. However, the Service Provider may use a blocked number to contact you by phone.

6. **Limitations of Telehealth Therapy Services:** While Telehealth Services offers several advantages such as convenience and flexibility, it is an alternative form of therapy or adjunct to therapy and thus may involve disadvantages and limitations. For example, there may be a disruption to the service (e.g. phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, the Service Provider might not see various details such as facial expressions. Or if audio quality is lacking, the Service Provider might not hear differences in your tone of voice that would normally be more evident should you be seen in the office.

   Additionally, the therapy office decreases the likelihood of interruptions. However, there are ways to minimize interruptions and maximize privacy and effectiveness. Our Service Providers will take every precaution to insure technologically secure and environmentally private psychotherapy sessions.

CONSENT TO TELEHEALTH SERVICES of Alliance Child & Family Solutions ("ACFS")

Consent for Telehealth Services Treatment: By my signature below, I am indicating that I have read and understand all of the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I understand that I have the right to ask questions of the Service Provider or Staff about the above information at any time. I also acknowledge by my signature below that:

a. I voluntarily agree to receive online Treatment or Services via telehealth for an assessment, continued care, treatment, or other services and authorize ACFS to provide such care, treatment, or services as is considered necessary and advisable.

b. I understand that there will be no recording of any of the online sessions and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

c. **I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location.** I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversations.

d. I consent to the use of various forms of communication via technology including phone, e-mail, text, and video as is determined necessary for my care.

This Policy is signed, submitted, and effective as of:

_____ _____

Signature (Client/Legal Guardian) **Date**

_____ _____

Name of Client **Name of Legal Guardian** (if applicable)

***NOTE: The signatures on this form are considered valid and true regardless of whether hand-signed or signed electronically through IntakeQ, AdobeSign, DocuSign, DrChrono, OnPatient, SimplePractice, or another approved electronic venue. The signatures above / on this form also indicate that I am consenting to all of the above statements AND all Practice Policies / Forms of the Agency with my electronic signature, even if the signature does not appear on the exact lines above or at the end of each document.**

*****PLEASE NOTE THAT NO SIGNATURE MAY BE PRESENT ON THIS FORM. A SIGNATURE ON THE FORM "*CONSENT TO ALL PRACTICE POLICIES WITH ALLIANCE CHILD & FAMILY SOLUTIONS ("ACFS")*" IS SUFFICIENT TO INDICATE AGREEMENT TO THE POLICIES WITHIN THIS FORM*****

CONSENT TO IN-PERSON SERVICES with Alliance Child & Family Solutions ("ACFS")

THIS FORM IS STANDARD FOR ALL CLIENTS TO BE AWARE OF OUR POLICIES, EVEN IF NOT PERTAINING TO YOUR UNIQUE SITUATION. PLEASE STILL READ IN FULL & SIGN.

1. **Provision of In-Person Services:** This document contains important information for Service Providers, Client(s), and their Legal Guardian(s) who choose to resume in-person services in light of the COVID-19 public health crisis (or other public health risk). This document covers the risks and benefits associated with receiving in-person services, which are defined as services in home, provider office, school-based site, or another physical location as agreed upon by both parties and as is determined to be in the best interest of the Client receiving Services.

2. **Qualification for In-Person Services**: In-Person services will be dependent on a number of factors, including Agency availability (*dependent on federal, state, local, professional licensing regulations, and liability insurance guidelines; an office location near Client; scheduling able to accommodate Client to be safely seen in-person; sufficient sanitization supplies; etc.*), Service Provider availability (*not all Service Providers may elect to offer in-person services*); Client needs and Client availability.

3. **Stance on COVID-19:** Our goal is to provide a safe environment for our Service Providers, Clients, and our Texas community. ACFS believes that preventive measures and strong communication are key to reducing risk to get ahead of widespread illnesses. As such, ACFS is making in-person determinations based on the following:
    a. The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. **Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with in-person counseling.**
    b. The COVID-19 virus has a long incubation period. The Service Provider or Client may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.
    c. Due to the frequency and timing of visits by other clients, the characteristics of the virus, and the characteristics of in-person therapy, there is an elevated risk of you contracting the virus simply by being in-person for any length of time.
    d. In general, the disease can be spread via droplets or "water spray" which can linger in the air for a long time, allowing for transmission of the COVID-19 virus to those nearby.

4. **Commitment to Minimize Exposure:** ACFS has taken steps to reduce the risk of spreading the coronavirus within the office. Our efforts include:
    a. Practicing the same preventive measures that we are asking of our Clients, such as to:
        - Avoid close contact with individuals showing signs of illness.
        - Avoid touching your eyes, nose, and mouth without first washing your hands. Practice proper hand hygiene and cough etiquette.
        - Wash hands often with soap and water for at least 20 seconds. If soap and water are unavailable, use an alcohol-based hand sanitizer.
        - Stay home if sick.
        - Alert a healthcare provider immediately if believed to have been infected with COVID-19, including if exposed to someone with the virus and have signs/symptoms of infection, or about any recent travel to areas where COVID-19 is spreading.
        - Alerting the Direct Supervisor if believed to have been exposed on the job.
    b. Appointments will be scheduled at specific intervals to minimize the number of people in the waiting room and provide sufficient time for Therapists to wipe down surface areas and frequently touched items in the office.
    c. Seating in the waiting room and offices has been arranged for appropriate physical distancing. Therapists will maintain safe distancing to the extent possible during clinical treatment. Physical contact is not permitted.
    d. We ask all Clients to wait in their cars or outside until no earlier than 5 minutes before their appointment times. Commonly touched items and areas are sanitized after each use. Common areas are thoroughly disinfected at the end of each day.
    e. Therapists and Staff are required to wear masks.
    f. Restroom soap dispensers are maintained, and everyone is encouraged to wash their hands.
    g. Hand sanitizer that contains at least 60% alcohol is available in all in-person locations.

5. **Risks of Opting for In-Person Services**: By coming to the office, Client is assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if Client travels by public transportation, cab, or ridesharing service.

6. **Individuals Participating in Face-to-Face Services**: If both Service Provider and Client agree to in-person services for some or all future services, it is with the understanding that the Agency or Service Provider may require a return to telehealth services if necessary for everyone's health, safety, and well-being.

   Client may determine at any time to stay with or return to telehealth services as long as it is feasible and clinically appropriate. Reimbursement for telehealth services may vary based on payor source and should be discussed with the Billing Department.

7. **If Service Provider, Client, or Accompanying Legal Guardian is Sick**: If Client or accompanying Legal Guardian arrives for an appointment with a fever, recent exposure, or other symptoms, the Service Provider will require the entire party (Client and accompanying Legal Guardian) to leave the office immediately. If an ACFS Staff Member tests positive for the coronavirus, you will be notified so you may be able to take appropriate precautions.

8. **Client Confidentiality in Case of Infection**: If you have tested positive for the coronavirus, the Agency or Service Provider may be required to notify local health authorities that you have been in the office. If this information must be reported, only the minimum amount of information necessary for data collection and contract tracing will be provided. No information will be provided about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Your Responsibility for ALL In-Person Services in order to Minimize Exposure:
By my signature below, I am indicating that I have read and understand all of the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I understand that I have the right to ask questions of the Therapist or Staff about the above information at any time.

I also acknowledge by my signature below that:

1. If my commute, other responsibilities, or activities put me in close contact with others (beyond my immediate family) or with individuals who are infected, I will let my Service Provider know prior to beginning any in-person services. **If the Client or a Household Resident tests positive for the infection, I will immediately let my Provider and an ACFS Staff know and we will then begin / resume treatment via telehealth.**
2. I will only keep an in-person appointment if I am symptom free. I will complete a temperature check before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, I agree to proceed using telehealth rather than coming into the office. Otherwise, I will contact my provider as far in advance as possible to move the visit to Telehealth.
3. I will wait in my car / outside until no earlier than 5 minutes before our appointment time. No additional family members apart from the Client and Legal Guardian(s) may/must be present for services with a minor child.
4. **I will wear a mask / facial covering for the entirety of in-person services and in all areas of the physical location, and understand that all ACFS staff will do the same. I will complete a questionnaire about the health and household exposure upon beginning any in-person visit. I also agree for myself (Client) and accompanying Legal Guardian(s) to participate in a temperature check upon arrival for services. I will wash my hands or use alcohol-based hand sanitizer when I enter the location.**
5. I will adhere to the safe distancing precautions we have set up in the waiting room and therapy area. For example, I will not move chairs or sit where there are signs asking not to sit. I will keep a distance of 6 feet and understand that there will be no physical contact with ACFS Service Providers.

CONSENT TO IN-PERSON SERVICES with Alliance Child & Family Solutions ("ACFS")

This Policy is signed, submitted, and effective as of:

_____ _____

Signature (Client/Legal Guardian) **Date**

_____ _____

Name of Client **Name of Legal Guardian** (if applicable)

***NOTE: The signatures on this form are considered valid and true regardless of whether hand-signed or signed electronically through IntakeQ, AdobeSign, DocuSign, DrChrono, OnPatient, SimplePractice, or another approved electronic venue. The signatures above / on this form also indicate that I am consenting to all of the above statements AND all Practice Policies / Forms of the Agency with my electronic signature, even if the signature does not appear on the exact lines above or at the end of each document.**

*****PLEASE NOTE THAT NO SIGNATURE MAY BE PRESENT ON THIS FORM. A SIGNATURE ON THE FORM "*CONSENT TO ALL PRACTICE POLICIES WITH ALLIANCE CHILD & FAMILY SOLUTIONS ("ACFS")*" IS SUFFICIENT TO INDICATE AGREEMENT TO THE POLICIES WITHIN THIS FORM*****