



Agape Child & Family Services Clinical Services – Consent for Treatment

Agape Child & Family Services is a nonprofit organization that provides a variety of services to children and families across the Memphis metro area. Our mission is to be a Christ-centered ministry that is dedicated to providing children and families with healthy homes.

Benefits and Risk of Therapy:

Research has shown that therapy can help a wide variety of problems for children, adolescents, and adults. However, because therapy is a cooperative effort between client and therapist, participation in therapy does not guarantee problem resolution or that the client necessarily will feel better. As with any treatment, whether psychological or medical, therapy should be entered into with appropriate consideration of the potential benefits and risks. If you have any questions about what to expect from therapy, please ask your therapist. It is your responsibility to provide relevant and accurate information as a basis for receiving services and participating in service decisions. Prior to engaging in therapy, we ask you to read and sign this agreement to provide such information to the best of your abilities.

Confidentiality:

Records and information collected about clients will be held and released in accordance with state and federal laws governing confidentiality of client records and information. Disclosure of information regarding services provided to the client is generally released to another party only with the client's written permission. Exceptions to this rule include the following cases: 1) when there is imminent danger to the client or another person, 2) when child abuse or neglect is suspected, 3) when disclosure must be made to medical personnel in a medical emergency, and 4) when the therapist is compelled by law to disclose client records or information. Client information and records are available to agency personnel for purposes of research, report, and quality assurance review. Clients who file insurance claims consent to review of records by an agent of the insurance company.

Staff Credentials:

All counselors on the Agape Clinical Services team possess master's level or higher clinical degrees and competence in individual, group, marital, and family counseling. As a commitment to standards of excellence in the area of counseling, the Agape Clinical Services counselors adhere to state statutes regulating their discipline and the standards of practice mandated by their professional and regulatory agencies.

Clients with Disabilities:

It is the policy of the Agape Clinical Services and Agape Child & Family Services, Inc. to accommodate clients with disabilities, pursuant to federal and state law. Any client with a disability who needs accommodation should inform Agape staff prior to receiving services. Clients with disabilities are also encouraged to inform the Clinical Director or Clinical Coordinator at (901) 323-3600 of their need for accommodation.

Nondiscrimination Policy:

In accordance with Title VI of the Civil Rights Act of 1964, Agape Child & Family Services, Inc., does not discriminate against participants or clients on the basis of race, color, or national origin. Services are



offered to all eligible persons. If you believe that Agape Child & Family Services, Inc., has discriminated against you, contact your Title VI Representative at (901) 323-3600.

Fee Policy:

The fee for counseling services provided through Agape Child & Family Services, Inc. is \$120.00 per 50-minute session. Reimbursement benefits for counseling services may be available to you through your medical insurance policy. You are expected to pay for the initial evaluation and for any deductible expenses, co-payments, and uncovered charges at the time services are rendered. If you do not have insurance benefits or the ability to pay the standard fee, payment for services can be arranged based on your family's annual gross income. Payment may be made by cash, check or credit/debit card. There is a \$35.00 fee for returned checks.

Professional Services:

Regular office hours are from 8:30 a.m. until 5:00 p.m. Monday through Thursday, and from 8:30 a.m. until noon on Friday. Appointments outside these hours may be arranged by mutual agreement with your therapist following your first appointment.

CONSENT FOR TREATMENT

I do hereby authorize and give my consent to Agape Child & Family Services, Inc. to provide treatment in accordance with the customary standards of practice specified by the state and federal laws, regulatory agencies, and professional disciplines governing the professionals on staff. I understand that I may revoke this consent at any time by advising Agape in writing.

I have read, understand, and agree to the conditions of treatment described in this document.

Client/Participant Name: _____

Client/Guardian Signature: _____ Date: _____
(Client/Participant signs if 16 or older)

Witness Signature: _____ Date: _____

I agree to allow a representative Agape Child & Family Services, Inc., to contact me regarding my experience with counseling services I have received at this agency. The phone number where I can be reached for this purpose is _____.

Client/Participant Name: _____

Client/Guardian Signature: _____ Date: _____
(Client/Participant signs if 16 or older)

Witness Signature: _____ Date: _____



Agape Child & Family Services Digital Communication Consent Form

Risk of Using Email/Texting

The use of email and text message has a number of risks that clients should consider prior to the use of email and/or texting. These include but are not limited to the following:

- Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Senders can easily misaddress an email or text and send the information to an undesired recipient.
- Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
- AGAPE has a right to inspect emails sent through their company systems.
- Emails and texts can be intercepted, altered, forwarded, or used without authorization or detection.
- Emails and texts can be used as evidence in court.
- Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party. Email messages are sent over the Internet and are not encrypted, are not secure and may be read by others. Email communications with

Agape email may NOT be encrypted and, therefore, Agape can NOT guarantee the confidentiality and security of any information the client sends to or that Agape sends to the client via email. Text messages are even less secure than e-mail, and the same conditions apply.

Conditions for the Use of Email and Texts

Agape cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Clients/Legal Guardians must acknowledge and consent to the following conditions:

- In a medical emergency, do not use email or text message, call 911.
- If you have an urgent problem during regular business hours, please call your therapist or the main office at 901-323-3600.
- Emails should not be time-sensitive. Agape cannot guarantee that any email and/or text will be read and responded to within any particular period of time.
- Email and text messages may be filed electronically into your medical record.
- Clinical staff will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/legal guardian's written consent, except as authorized by law.
- Clinical staff will limit text messages and emails to brief inquiries or responses regarding scheduling.
- Client should use their best judgment when considering the use of email or text messages for communication of sensitive medical information. Clinical staff are not responsible for the content of messages.
- Agape is not liable for breaches of confidentiality caused by the client or any third party.
- It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.



In general, the HIPAA privacy gives individuals the right to request a restriction on uses and disclosures of their personal health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means such as sending correspondence to the individual's office instead of the individual 's home.

I wish to be contacted in the following manner (initial all that apply):

Home Telephone: _____

Okay to leave message with detailed information

Leave message with call back number only

Cell Phone Telephone: _____

Okay to leave message with detailed information

Leave message with call back number only

Okay to send text messages

Work Telephone: _____

Okay to leave message with detailed information

Leave message with call back number only

Written Communication: _____

Okay to mail to my home address

Okay to mail to my work office

Okay to send emails to: _____

Withdrawal of Consent

I understand that I may revoke this consent at any time by advising AGAPE in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.



Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of phone, mail, email and/or texts between Agape staff and me, and consent to the conditions and instructions outlined, as well as any other instructions that Agape may impose to communicate with me by email or texts.

Client/Participant Name: _____

Client/Guardian Signature: _____ Date: _____
(Client/Participant signs if 16 or older)

Witness Signature: _____ Date: _____





Agape Child & Family Services
Acknowledgement of Client Intake Handbook for Clinical Services

Intake Handbook Components – Please Initial

_____ HIPAA Notification for Clients

_____ Rights and Responsibilities

_____ Agape Behavior Support and Management Policy

_____ Grievance Procedures/Form

I have received and reviewed all the information in the client intake handbook. By signing, I am agreeing to all procedures and practices listed in the intake handbook. I understand that I have the right to ask Agape staff any questions.

Client/Participant Name: _____

Client/Guardian Signature: _____ Date: _____
(Client/Participant signs if 16 or older)

Witness Signature: _____ Date: _____



Agape Child & Family Services Technology-Assisted Service Delivery Informed Consent

Technology-assisted service delivery is provided by any means other than a face-to-face visit. In technology-assisted service delivery, personal health information may be exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, and electronic client records monitoring are all considered technology-assisted services.

Client/Guardian's Initials

_____ I understand that technology-assisted service delivery involves the communication of my personal health information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the technology-assisted services at any time. This will not change my ability to receive future services from Agape Child & Family Services.

_____ I understand that all electronic communications carry some level of risk. While the likelihood of risks associated with the use of technology-assisted services in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
- Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
- Despite reasonable efforts on the part of my service provider, the transmission of personal health information could be disrupted or distorted by technical failures.

_____ I agree that information exchanged during my technology-assisted service will be maintained by Agape Child & Family Services' staff that are involved in my care.

_____ I understand that personal health information, including client records, are governed by federal and state laws that apply to technology-assisted service delivery.

_____ I understand that Skype, FaceTime, Zoom, Google Duo, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

_____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

_____ The provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

_____ I agree that I have verified to my provider my identity and current location in connection with the technology-assisted services. I acknowledge that failure to comply with these procedures may terminate the technology-assisted service.

_____ I understand that I have a responsibility to verify the identity and credentials of the service provider rendering my care via technology-assisted service and to confirm that he or she is my service provider.

_____ I understand that electronic communication cannot be used for emergencies or time sensitive matters.

_____ I understand that electronic communication may be used to communicate highly sensitive personal health information.

_____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of personal health information and images during technology-assisted service delivery.



_____ I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the existing emergency 911 services in my community.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

Client/Participant Name: _____

Client/Guardian Signature: _____ Date: _____
(Client/Participant signs if 16 or older)

Witness Signature: _____ Date: _____