General Office Procedures

Welcome to Willowstone Family Services! We are grateful for the opportunity to serve you, and hope that our time together will be beneficial. This packet is designed to give you important information about our agency, and to give your therapist the information necessary to provide you the best services possible. Please read this carefully, and completely fill out all of the following pages. If you have any questions, please ask for assistance.

Business Hours: You may get in touch with us by either dropping by or calling us during our normal business hours or by leaving a message on our voicemail after hours. At present, our business hours are as follows:

Monday: 8:00 am – 8:00 pm
Tuesday: 8:00 am – 8:00 pm
Wednesday: 8:00 am – 6:00 pm
Thursday: 8:00 am – 8:00 pm
Friday: 8:00 am – 2:00 pm

Contact Information: We can be reached at 765-423-5361, contact@Willowstone.org, through our website at www.Willowstone.org, or by contacting us at: Willowstone Family Services, 615 North 18th Street, Suite 101, Lafayette, IN 47904.

Appointments: We will make every effort to find an appointment time that works for you. In return, we ask that you be careful about keeping your appointments. If you must cancel, you are expected to give us 24 hours notice (please note that you can leave a voicemail message during hours we are not open). Failure to give us advanced notice will result in a charge of $35.00, except in emergency situations. If this happens, please discuss it with your therapist as soon as possible.

Fees: Our full fee is $135.00 per 50-minute session. We can provide some financial assistance with the fee, based on your income and family size. We can also directly bill insurance companies. Payment is due at the time of service. Should you experience an unexpected financial hardship and are unable to pay your assessed fees for service for a period of time, please discuss this with your therapist as soon as possible, so that we can work with you to establish a temporary fee reduction or payment plan so that we can help prevent interruption of your services.

Payment Procedures: You are expected to pay at the time you receive services. If you have health insurance and would like us to bill your insurance for your services, please make sure you give us a copy of your insurance card at the first visit.
Please note that should your insurance fail to reimburse for your services, you will be held liable for the expenses incurred. If you do not have health coverage and cannot afford our full fee, please ask us about our sliding fee.

Courtesy Reminder Calls: Although Willowstone Family Services, provides a Courtesy Reminder Call, please note that ultimately it is your responsibility to know when your scheduled visit is.

Child Care: Children who are able to play **quietly** without close supervision may be left in the waiting room. We are not able to watch children of any age who need to be supervised or entertained. If your children are disturbing either staff or other clients, we will ask you to promptly take care of the situation.

Client Complaint Procedure: We will do our best to make your experience here at Willowstone Family Services a good one. If you ever have a concern or complaint about anything, please bring it to our attention. If you are uncomfortable speaking with your counselor about the issue, please ask to speak with the Director of Clinical Services, Lisa Marie Lucy, at 765-423-5361 EXT 2353.

After Hour Emergencies/Phone Calls: Our telephone is answered during posted business hours by the front office staff to ensure that you are helped promptly. Please note that we do not answer calls after hours. If you have an emergency after hours, call the crisis line at 765-423-2255, 911, or go to an emergency room.

Willowstone family services Counseling Client Face Sheet

FIRST NAME: **PREFERRED NAME:**	**MIDDLE:**		**LAST:**
STREET ADDRESS			
CITY, STATE, ZIP			
LAST 4 DIGITS OF SOCIAL SECURITY NUMBER		**DATE OF BIRTH:**	**PHONE NUMBER:**

EMERGENCY CONTACT:	**PHONE:**
RELATIONSHIP:	
FAMILY DOCTOR:	**PHONE:**

SEX (as reported to insurance)**:** ☐ MALE ☐ FEMALE

GENDER: ☐ MALE ☐ FEMALE ☐ TRANS WOMEN ☐ TRANS MALE ☐ NON-BINARY

RACE

☐ WHITE
☐ BLACK OR AFRICAN AMERICAN
☐ HISPANIC OR LATINO
☐ ASIAN
☐ NATIVE AMERICAN OR ALASKA NATIVE
☐ NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER
☐ OTHER OR MULTI-RACIAL

MARITAL STATUS

☐ SINGLE ☐ SEPARATED
☐ MARRIED ☐ WIDOWED
☐ DIVORCED

OTHER HOUSEHOLD MEMBER(S)

RELATIONSHIP	FIRST NAME	LAST NAME	SEX	BIRTH DATE	RACE
			M F	/ /	
			M F	/ /	
			M F	/ /	
			M F	/ /	
			M F	/ /	
			M F	/ /	
			M F	/ /	

SECONDARY HOUSEHOLD MEMBER(S)

RELATIONSHIP	FIRST NAME	LAST NAME	SEX	BIRTH DATE	RACE
			M F	/ /	
			M F	/ /	
			M F	/ /	
			M F	/ /	
			M F	/ /	

EMPLOYMENT/SCHOOL STATUS - CHECK ALL THAT APPLY

□ EMPLOYED FULL-TIME □ EMPLOYED PART-TIME	□ UNEMPLOYED □ RETIRED	□ PART-TIME STUDENT □ FULL-TIME STUDENT

EMPLOYER/SCHOOL:

OTHER PAYMENT INFORMATION

PRIMARY INSURANCE PROVIDER	GROUP NUMBER:	INSURED ID NUMBER:
	INSURED:	RELATIONSHIP:
OTHER INSURANCE PROVIDER	GROUP NUMBER:	INSURED ID NUMBER:
	INSURED:	RELATIONSHIP:

ANNUAL HOUSEHOLD INCOME BASED ON FAMILY SIZE (Check One)

Size of Family Unit	Below Poverty Level (Below 100% Poverty)	Low Income (100-200% Poverty)	Above Low Income (Above 200% Poverty)
1	< $11,770	$11,770 - $23,540	> $23,540
2	< $15,930	$15,930 - $31,860	> $31,860
3	< $20,090	$20,090 - $40,180	> $40,180
4	< $24,250	$24,250 - $48,500	> $48,500
5	< $28,410	$28,410 - $56,820	> $56,820
6	< $32,570	$32,570 - $65,140	> $65,140
7	< $36,730	$36,730 - $73,640	> $73,460
8	< $40,890	$40,890 - $81,780	> $81,780

I hereby allow Willowstone Family Services, to speak with the following person(s) regarding financial information and/or scheduling counseling appointments on my behalf:

_____ _____ ☐ Financial Information
Name & Relationship Phone Number ☐ Scheduling

_____ _____ ☐ Financial Information
Name & Relationship Phone Number ☐ Scheduling

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT IF THE ABOVE NAMED PARTY REFUSES TO PAY.
I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Client/Guardian Signature: _____ Date:_____

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Reminder Notification & Contact Method

Client Name	
Guardian Name (if applicable)	
Email address	

Willowstone Family Services is grateful for your patronage. Willowstone staff members work hard to ensure that you and all of our clients' needs are accommodated. We ask that you please help us keep every appointment slot filled, as there are many clients waiting for our services.

We know that life gets busy sometimes, and ask you to please call us at 765-423-5361 anytime you need to verify your next appointment time or to cancel an appointment to avoid No Show Fees.

Willowstone will email you appointment reminders as a courtesy, *however,* there may be times when service does not happen on schedule. It is still the client's responsibility to remember when your appointments are and cancel in the timeframe required to avoid additional fees.

If you have confidentiality or security concerns about being emailed appointment reminders, please initial below:

_____ I do not wish to be emailed appointment reminders.

If you initialed above, please choose your preferred method for receiving reminder notifications by initialing **one** of the options below:

_____ I wish to be texted appointment reminders to this mobile number _____

_____ I wish to receive a phone call to this phone number _____

Willowstone Family Services will also include you in our email list to receive agency updates and opportunities. Please let us know if you do not wish to receive these emails by initialing below.

_____ I do not wish to receive informative emails from Willowstone.

Client/Guardian Signature: _____ Date: _____

COUNSELING FEE AGREEMENT & APPOINTMENT POLICY

Client Name:_____

By initialing below, I acknowledge that I have reviewed and am aware of Willowstone Family Services policies for payment and insurance billing:

The Current Fee for Counseling is $135.00 per hour.

PAYMENT FOR SERVICES:

_____ 1 Payment is due at the time of service unless prior arrangements have been made with the Willowstone billing office.

_____ 2 Even though Willowstone provides a courtesy reminder call, it is ultimately your responsibility to keep track of your appointment times and dates.

_____ 3 If at any time your account balance is equal to or greater than $50.00, Willowstone will review your account and may refuse to schedule further appointments until a payment is made or a payment plan has been established.

NO SHOW AND CANCELLATION POLICY:

_____ 4 **If you will not be able to keep an appointment, you must give the agency a 24 hour notice. Failure to do so will result in a no show/late cancellation fee of $35.** We will make every effort to find appointment times that work for you. In return, we ask that you be respectful about keeping your appointments. If you must cancel an appointment, you may do so by calling during our regular business hours or by leaving a voicemail message after hours. In emergency situations, this fee may be waived. If this is the case, you must discuss the situation with your therapist prior to your next session.

_____ 5 The no show/late cancellation fee is not covered by your health insurance or other funding source and you are responsible for this payment.

_____ 6 Excessive no shows or cancellations may result in termination of services.

HEALTH INSURANCE POLICY:

_____ 7 If you have private health insurance, it is your responsibility to provide a copy of your insurance card to Willowstone if you want them to submit claims for reimbursement. Please note that Willowstone's full fee for service is $135.00 per hour and if you have insurance, this is the amount that will be billed to your insurance company.

_____ 8 Willowstone will attempt to bill your insurance, but ultimately you are responsible for whatever amount is not reimbursed (i.e., amount applied to deductible, co-payments, unreimbursed services, spend-downs, etc.).

_____ 9 If you receive a reimbursement check from your insurance company, please inform Willowstone as soon as possible.

SLIDING FEE POLICY:

_____ 10 Willowstone offers a sliding fee based on the household's income. Hourly rates for counseling services range from $25-135. Every six months your sliding fee will be reassessed. At that time, you will be asked to bring in current proof of household income. If changes occur in your living, family, or financial situation, you may be eligible for a reduced fee and should talk to the front desk staff about this.

I, the undersigned, have received a copy of this agreement, and it has been discussed with me. I understand and agree to comply with the agreement.

Client/Guardian Signature_____ Date_____

Printed Name of Guardian (if applicable)_____ Date_____

Agency Representative_____ Date_____

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family services

Counseling Intake Information

Client Name: _____ **Age**: _____

Briefly describe the reason you decided to seek our services.

_____

_____

_____

Please check any of the following that you are currently struggling with:

Relationship Difficulties

- Marital/Partner
- Communication
- Multi-family
- In-laws
- Parents
- Brother/Sister
- Sexual
- Separation
- Divorce
- Dating
- Premarital

Situational Difficulties

- Death of a Loved One
- Violence (real/threatened)
- Physical Abuse (past/current)
- Sexual Abuse (adult/child)
- Legal
- Major Loss/Changes
- Stress
- Past
- Friends
- Religion
- Decision Making

Physical/Health Difficulties

- Headaches
- Stomach
- Physical Disability
- Bed-wetting
- Eating Disorder
- Sleep
- Chronic Pain

Emotional Difficulties

- Depression
- Suicidal Thoughts
- Suicidal Actions
- Sadness
- Unhappiness
- Nervousness/Panic Attacks
- Anger/Temper

Work/School Difficulties

- Unemployed
- Job/School
- Education
- Finances
- Career Choices
- Learning Disability

Children

- Misbehaving
- Child having Problems
- Parenting Issues
- Parent-Child Conflict (self)
- Parent-Child Conflict (partner)

Personality Concerns

- Fears
- Loneliness
- Sexuality Issues
- Confusion
- Relaxation
- My Thoughts
- Alcohol/Drug Use or Abuse
- Low Self-esteem
- Shyness
- Guilt
- Assertiveness
- Self-control
- Compulsive Gambling

Please list three items that are causing you the MOST difficulty:

1) _____ 2) _____ 3) _____

Have you had counseling in the past? ○ **Yes** ○ **No**

When? _____

Where? _____

For how long? _____

For what reason? _____

Problems with Coping

Please check all that apply to you.

- ○ Moody or crying more than usual
- ○ Problem remembering things
- ○ Panic attacks
- ○ Feeling guilty, worthless, hopeless
- ○ Hyper/Too much energy
- ○ Disturbing thoughts you can't stop
- ○ Difficulties concentrating
- ○ Withdrawing from others
- ○ People picking on you
- ○ Fatigue/Low energy
- ○ Loss of interest in things
- ○ Extreme worry of fears

Repeated actions you can't stop

- ○ Can't stop counting/checking things
- ○ Can't stop washing hands/body

Hallucinations

- ○ I hear things that are not real
- ○ I smell things that are not real
- ○ I see things that are not real
- ○ I feel things that are not real

Sleep Difficulties

- ○ Waking up in the middle of the night
- ○ Waking up too early
- ○ Nightmares
- ○ Can't fall asleep
- ○ Sleeping too much

Appetite Difficulties

- ○ Gaining weight
- ○ Not hungry/eating
- ○ Feeling sick to your stomach
- ○ Losing weight
- ○ Throwing up after eating

Self-harm

- ○ I cut myself
- ○ I hit myself
- ○ I burn myself
- ○ Other

List any previous Suicide Attempts (if none, write 'none')

When? Method?

_____ _____

_____ _____

_____ _____

Have you recently been thinking about hurting or killing yourself? ○ Yes ○ No

Have you recently been thinking about hurting or killing someone else? ○ Yes ○ No

List any health problems you are currently receiving treatment for:

_____

_____

_____

Are you currently taking any medications? Yes No

Medication Name Dosage Prescribing Physician

_____ _____ _____

_____ _____ _____

_____ _____ _____

If more please list on a separate piece of paper

Who is your family Doctor? _____

When was your last physical exam? _____

Please describe your current use of alcohol/drugs, include type, amount and frequency (if none, write 'none').

_____

_____

_____

Does your family have a mental health or substance abuse history? ○ Yes ○ No
If yes, please list.

_____

_____

Are you currently involved in any legal proceedings? ○ Yes ○ No
If yes, please list.

_____

_____

What is your religious preference? _____

Please list any family, friends, support groups or others that are helpful to you:

_____

_____

_____

Your goals in Counseling

Goals are very important in counseling. They provide us with a focus and direction that will help us to help you. Please list the goal(s) that you hope to attain, be as specific as possible.

1) _____

2) _____

3) _____

How many sessions do you THINK you will need to attain these goals? (your best guess) Please circle.

1-3 sessions 4-6 sessions 7-9 sessions

10-12 sessions 13-15 sessions Other: _____

COUNSELING SERVICES AND INFORMED CONSENT FORM

Staff: Willowstone Family Services specializes in individual, family and couples counseling, focusing on general adult issues as well as child and adolescent counseling. All of our therapists have a master's degree and/or Ph.D. in a counseling field and most are licensed. Occasionally, we host a student intern that is currently attending graduate school to become a therapist. Feel free to ask your therapist about his or her qualifications including their licensure status.

Confidentiality: We understand that the information you share in counseling is of a personal nature, and want you to be assured that what you discuss with your therapist will be kept confidential. Therefore, it is important for you to know that your therapist may occasionally discuss your case with his/her clinical supervisor or with other therapists at Willowstone Family Services. This allows your therapist to get feedback to ensure the best services possible. By signing this document, you are acknowledging that you understand this is our policy and you are giving your therapist consent to speak confidentially about your case with other counseling staff when needed. Otherwise, your therapist is very committed to maintaining your confidentiality and will only speak with others under the following circumstances:

- As is outlined on the Consent to Use and Disclose Personal Health Information attached to this paperwork.
- When you give us specific written permission to share information regarding your treatment with a specific person or organization;
- In situations where we are required by law to disclose your information. The three situations in which this might occur are:
    1) When there is a court order or subpoena;
    2) When there is reasonable suspicion of child or adult abuse, neglect, and/or endangerment;
    3) If we believe that you are in real danger of harming yourself or someone else.

Goals and Outcomes: In your first sessions, your therapist will discuss what your goals for treatment are. Generally, counseling is most beneficial when individuals are willing to examine their own thoughts, feelings, and behaviors, and willing to change how they interact with others or the choices they make. You will determine the nature and amount of change you wish to make. At any time in treatment that you do not feel you are accomplishing your goals, please speak with your therapist immediately.

Benefits and Risks: Most people experience improvement or resolution to the concerns that brought them to counseling, but of course there are no guarantees; and there are some risks. For example, counseling could open up new levels of awareness that may cause some pain and anxiety.

Termination Criteria: If you have not had contact with your therapist for more than two months (unless you had prior approval) your file will be closed. If you decide that you would like to resume therapy after your file has been closed, please be aware that you may have to be put on a waiting list and are not guaranteed immediate services.

Evaluations: Please note that Willowstone Family Services does not do custody evaluations, home studies and/or legal mediation. In certain special circumstances we may respond to a request to write a report or appear in court. In such cases, you will be required to pay a full fee rate ($135 per hour). Reports will only be released when full payment is received.

After Hour Emergencies/Phone Calls: Our telephone is answered during posted business hours by the front office staff to ensure that you are helped promptly. Our therapists work varied schedules therefore your therapist may not be available every day of the week to assist you. However, arrangements can be made for you to speak to a supervisor and/or a different therapist if needed. This therapist will make every effort to be helpful to you. Please note that we do not answer or return calls after hours. If you have an emergency after hours, call the crisis line at 765-742-0244, call 911, or go to an emergency room.

Email Communication: It is important to be aware that that email communication can be relatively easily accessed by unauthorized people, and therefore can compromise the privacy and confidentiality of such communications. For your online safety, please do not discuss content that is personal to you; please bring it to your session. Also, please do not use email for emergencies as email communications are not always monitered on a daily basis.

_____ I have received or have been offered a copy of the Notice of Privacy Practices statement.

_____ I have completed the Counseling Fee Agreement and Appointment Policy Form.

By signing my name below, I certify that I have read this consent form, and that I agree to all provisions contained therein. I do also hereby agree not to hold my Therapist or Willowstone Family Services responsible for any consequences and I release them from all liability.

_____ _____

Client's printed full name Client/Guardian Signature Date

_____

Agency Representative Date

Willowstone family services

CLIENT BILL OF RIGHTS

1. The right to have your personal dignity, privacy and freedom of choice respected.

2. The right to services which promote your freedom of choice as much as possible.

3. The right to know all about your condition, current or proposed treatment plans, and alternative treatments.

4. The right to accept or refuse services after a full explanation of the consequences of your choice. A parent or legal guardian may make this choice for a minor.

5. The right to have your treatment guided by a personal service plan which is written to fit your specific mental health, physical health, social and economic needs, and which shows that you will receive appropriate services to meet those needs either here, or by referral.
6. The right to freedom from unnecessary or excessive medication.

7. The right to know about and refuse observation by one-way mirrors, tape or video recorders, or photographs.

8. The right to get a second opinion or legal advice from outside sources, at your expense.

9. The right to confidentiality and privacy regarding your treatment in accordance with State and Federal law. See the Notice of Privacy Practices for more details.

10. The right to receive an explanation if services are to be denied and the right to be involved in planning for the consequences of service ending.

11. The right to not be discriminated against in receiving services because of religion, race, color, creed, sex, national origin, age, lifestyle, gender identity, sexual orientation, physical or mental disability, developmental disability, or inability to pay.

12. The right to know how much our services cost.

13. The right to file a complaint. We hope that you will discuss the situation with your service provider first. When discussion with your service provider fails to resolve the issues, please ask to speak with their supervisor at (765) 423-5361. The complaint will be investigated, and you will receive a written response within 10 days. If you believe that you still have not received a satisfactory solution, you have the right to file a written complaint with the Management Team. You will receive a written response within 30 days.

CLIENT RESPONSIBILITIES

You are responsible for providing accurate information about your current issues and past illnesses.

You are responsible for following your treatment or service plan. If you do not understand your plan, you need to speak to your case worker or therapist.

You are responsible for reporting unexpected changes in your condition to your provider.

You are responsible for your actions if you do not follow your provider's instructions or refuse treatment.

You are responsible for keeping any appointments and when unable to do so, notify your provider 24 hours in advance.

You must assure that financial obligations of your health care are fulfilled and that any changes in your insurance are reported immediately if appropriate.

You must follow these guidelines or the agency reserves the right to refuse services:

- You are not permitted to bring any kind of weapon into the agency.
- You are not permitted to use or bring illegal drugs or alcohol into the agency.
- You are not under the influence of illegal drugs or alcohol during service provision.

By signing below, I am indicating that I have read and understood my rights and responsibilities as a client at Willowstone Family Services. A staff member has answered any of my questions, and explained my rights to me in a way that I can understand. Also, by signing below, I am indicating that I have been offered a <u>Notice of Privacy Practices</u> statement.

Client/Guardian Signature_____ Date_____

Agency Representative_____ Date_____

Note: If there is no signature on this form, the Willowstone Family Services representative shall indicate the following (check one):

____ The client is physically incapable of signing this form.

____ The client is not able to understand this form due to a mental impairment.

Consent to Use and Disclose Personal Health Information

I, _____, do hereby enter into an agreement between myself and WILLOWSTONE FAMILY SERVICES. (If I am serving as the legal representative of another client, their name is listed here: _____.)

I understand that when my therapist at Willowstone Family Services examines, treats, or refers me, they will be collecting what the law calls Protected Health Information (PHI). I understand that this information is needed to keep a file about me and/or others involved in my treatment, and that it may be necessary to share my PHI with other people or organizations necessary to provide treatment for me, arrange for payment of services, or for administrative purposes. I have been informed that the NOTICE OF PRIVACY PRACTICES explains in more details my rights and in what way my PHI can be used.

I acknowledge that if I do not sign this Consent Form agreeing to what is in the Notice of Privacy Practices, that my therapist and/or other representative of WILLOWSTONE FAMILY SERVICES cannot treat me.

I understand that if I am concerned about some of my Personal Health Information, I have the right to ask my therapist or other representative of Willowstone Family Services not to share some of this information for treatment, payment, or administrative purposes. I realize that Willowstone Family Services and its representatives will try to respect my wishes, but that they are not required to agree to these limitations. However, if Willowstone Family Services, or its appropriate representative does agree, Willowstone Family Services promises to comply with my wishes.

After I have signed this consent, I have the right to revoke it (by submitting a written letter stating I no longer consent to these terms) and that Willowstone Family Services will comply with my wishes about using or sharing my PHI information from that time on. I realize that if Willowstone Family Services has already shared some of my PHI, this cannot be changed.

_____ _____

Printed name of client Date

_____ _____

Signature of Client or Their Personal Representative/Legal Guardian Relationship to Client

_____ _____

Willowstone
family services

Consent for a Minor to Receive Services

I hereby authorize Willowstone Family Services to provide counseling services to my child/children. I understand that I will have an opportunity to work with the therapist in developing a treatment plan. I also understand that in most cases, I can best help my child/children by willingly playing an active role in creating and implementing the treatment plan.

Name(s) of child/children to receive services:

_____born on ___/___/___

_____born on ___/___/___

_____born on ___/___/___

_____born on ___/___/___

This consent will expire on ___/___/___ (no more than one year from today).

I hereby verify that I have legal authority to authorize such services.

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Agency Representative Date

Willowstone
family services

TELETHERAPY INFORMED CONSENT

In an effort to provide adaptive services to our clients, and in response to the current public health crisis, Willowstone Family Services will begin to offer the option of tele-therapy or tele-psychotherapy (e.g. video conferencing and/or phone calls) to clients who opt in for this service. This is a unique service that can be a benefit in times in which face-to-face appointments are not feasible. Please read the following items and initial alongside each to indicate your understanding of the responsibilities and risks that may come with your participation in tele-therapy services.

1. I understand that there are potential benefits and risks of video conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
2. I understand that confidentiality still applies for tele-therapy services. I understand that Willowstone will be utilizing a HIPAA compliant platform, and no person will record the session without my written permission.
3. I agree to use the video-conferencing platform selected by Willowstone for our virtual sessions, and expect my provider/therapist will explain how to use it.
4. I understand that I will need to obtain access to use a webcam or smartphone during the session. Headphones are also helpful, though not required.
5. I understand that it is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session, and agree that I will do my best to ensure I obtain a space that is private for sessions. I understand this includes therapy sessions for my child, as applicable.
6. I understand it is important to use a secure internet connection rather than public/free Wi-Fi.
7. I understand it is important to be on time. If I need to cancel or change my tele-appointment, I agree to notify my therapist/provider 24 hours in advance by phone or email, per Willowstone policy and procedure.
8. I understand that I can still reach my provider via the office phone number at 765-423-5361, leave a voicemail, and they will return my call within one business day, likely from a blocked number.
9. I understand if I miss a scheduled appointment, no show and late cancellation fees will still apply. I am responsible for paying these in a timely manner.
10. I agree to creating a back-up plan with my provider (e.g. phone number where you can be reached) to restart the session or to reschedule it, in the event of technological problems.
11. I agree to create a safety plan, as applicable, that includes at least one emergency contact and the closest emergency room to my location, in the event of a crisis situation.

12. I understand that video sessions will be billed through my insurance, or to my Sliding Fee Scale agreement, as applicable. I also understand I am still responsible for any co-pay or deductible amount due.
13. I understand that due to insurance and licensing purposes, I am required to be physically located within the state of Indiana to participate in tele-therapy services with Willowstone.
14. I understand that my therapist/provider may determine that due to certain circumstances, tele-therapy is no longer appropriate and that we should resume our sessions in-person or facilitate a higher level of care, as appropriate.

I have read the above statements thoroughly and understand that I am responsible to follow and adhere to these guidelines. By signing below, I am agreeing to participate in tele-therapy with Willowstone Family Services.

Client Name _____

Client Signature _____ Date _____

Relationship to client, if a minor _____

Witness Name _____

Witness Signature _____ Date _____