CLIENT INFORMATION

Full Name (1)_____ SS#:_____ Birth Date: _____ Age ____

Full Name (1)_____ SS#:_____ Birth Date: _____ Age ____

Address 1:_____ City:_____ State:_____ Zip:_____

Address 2:_____ City:_____ State:_____ Zip:_____

Home phone:_____ Work phone: (1)_____ (2) _____

Cell phone: (1) _____ (2) _____ Is it okay to leave you a text or message? Yes No
I prefer messages left on the following number: (Please Circle) Home Work Cell

Employer: (1)_____ (2) _____

Referred By:_____

INSURED/RESPONSIBLE PARTY INFORMATION

Name: _____ Relationship to Client: _____ Birth Date_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone:_____ Work phone:_____

Employer: _____ SS#: _____

Insurance Company: _____

GENERAL INSURANCE INFORMATION

Marital Status:	Employment Status:	Client's Condition Related to:
Single? ❒Yes ❒No	Employed? ❒Yes ❒No	Employment? ❒Yes ❒No
Married? ❒Yes ❒No	Full-Time Student ❒Yes ❒No	Auto Accident? ❒Yes ❒No
Other:	Part- Time Student ❒Yes ❒No	Other Accident? ❒Yes ❒No

I authorize use of this form with all of my insurance submissions. I authorize the release of information to my insurance company. I understand that I am responsible for the full amount of my bill for services provided. I authorize direct payment to my service provider. I hereby permit a copy of this to be used in place of an original. If I decide not to use my insurance and self-pay, I understand no information will be given to my insurance company.

Print Your Name (1): _____

Signature (1):_____ Date:_____

Print Your Name (2):_____

Signature (2):_____ Date:_____

PRIMARY CARE PHYSICIAN CONSENT TO USE & DISCLOSE YOUR PROTECTED HEALTH INFORMATION

I authorize Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, RPT, to contact my Primary Care Physician (PCP) regarding my medical conditions as well as information pertaining to my psychological and emotional functioning. This information will be useful in treatment planning. I authorize the release of the information verbally or in writing. I am aware that this is encouraged by my insurance company.

Primary Care Physician: _____ Telephone: _____

I have the following health problems: _____

_____

I take the following medications: _____

❑ I do not permit Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, to contact my Primary Care Physician.

❑ I do not have a Primary Care Physician.

_____ _____

Client Signature **Date**

PSYCHIATRIST CONSENT TO USE & DISCLOSE YOUR PROTECTED HEALTH INFORMATION

I am currently under the care of a psychiatrist. I authorize Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, RPT, to contact my psychiatrist regarding my mental health care, services, and treatment planning. I authorize contact to be verbal or written.

Psychiatrist Name: _____ Telephone: _____

I take the following medications: _____

❑ I do not permit Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, to contact my Psychiatrist.

❑ I do not have a Psychiatrist.

Have you ever seen another therapist, counselor, or mental health professional? ❑Yes ❑No

If so, who _____

Reason for changing therapist? _____

****

I give permission for the following people to receive and give information regarding my mental health:

_____ _____ _____

Name & relationship **Name & relationship** **Name & relationship**

_____ _____

Client Signature **Date**

Carissa Rupp, Master of Arts, Provisionally Licensed Professional Counselor
Supervised by Julia Dooley, MA, LPC, RPT
737 Dunn Road
Hazelwood, Missouri 63042
(314) 744-9253 carissamrupp@gmail.com

CLIENT INFORMATION & CONSENT

THERAPIST

Carissa is a Provisionally Licensed Professional Counselor, (PLPC) under the direct supervision of Julia Dooley, MA, RPT, LPC #2015035429. She received her Bachelor of Science in Psychology, from University of Missouri- St. Louis, and has obtained her Master's Degree in Counseling through Lindenwood University.

Carissa takes a thoughtful, trauma-informed approach when working with her clients. She seeks to build a positive, collaborative therapeutic relationship with clients based on her belief that each person is inherently worthy and deserving of dignity and respect. Recognizing that everyone experiences the world around them differently, she strives to provide a safe, caring, compassionate, validating, and non-judgmental counseling environment for each of her clients.

Carissa has a special interest in working with trauma, sexual abuse and assault, rape, grief, and non-suicidal self-injury. She also has experience working with parents of children and teenagers with disabilities. Carissa tailors each therapy session to the unique needs of her client and moves at the pace that is comfortable for them.

MENTAL HEALTH SERVICES: BENEFITS & RISKS

While it may not be easy to seek help from a mental health professional, I hope that this experience will assist you in understanding your situation or problem and moving toward a resolution of this issue. A therapist has professional training and knowledge of human development and behavior and will make observations about your situation and will assist you in finding options for resolution of your issue(s). The therapist may utilize various therapeutic approaches in order to assist you in resolving your problem(s). You should be aware that entering into psychotherapy is a risk. Psychotherapy sessions can be painful at times. Often times, you may learn new information about yourself that you may not like. Often personal growth cannot occur until you are able to confront your issues and experience the associated feelings. These feelings may include pain, sadness, anger, or shame. The success of our work depends on quality effort of both therapist and client and the realization that you are ultimately in control of and responsible for the changes that result from psychotherapy. Specifically, one risk of psychotherapy is encountering (positive or negative) reactions from significant others to your new lifestyle choices/changes.

GOALS, PURPOSES, AND TECHNIQUES OF THERAPY

Psychotherapy may be one way to effectively treat your problem. There may be alternative ways to treat your problem. It is important for you to discuss any concerns you have regarding the therapist's treatment recommendations. The therapist encourages you to provide input into setting your goals for therapy and the therapeutic techniques used for treatment. As therapy progresses, these goals and techniques may change.

RELATIONSHIP

Your relationship with your therapist is a professional relationship. In order to preserve this relationship, the therapist cannot have any other type of relationship with you. Any personal or business relationships with you will undermine the effectiveness of the therapeutic relationship and therefore is strictly prohibited. Your therapist is committed to your mental health, but is not in the position to become socially or personally involved with you. Please note that the therapist cannot accept any gifts, or barter/trade services.

SESSION

Individual Therapy sessions are 50 minutes in length. The number of sessions needed depends on various factors and can be discussed during your session. Some insurance companies may provide a limited number of sessions under your designated plan. If your insurance company requires authorization for mental health services, it is your responsibility to obtain this authorization prior to our initial appointment. Requests for additional sessions from your insurance company will be requested by the therapist.

APPOINTMENTS & CANCELLATIONS

Sessions are by appointment only. To schedule an appointment, please call my cellular number, (314) 744-9253. If you think that you will be unable to attend a scheduled appointment, 24 hours advance notice is required in order to not be charged for the session. If you miss an appointment, it is your responsibility to contact the therapist to reschedule**. <u>If you do not show up for an appointment, and do not call to cancel your appointment prior to 24 hours of the missed appointment, all future scheduled appointments will be canceled.</u>** You may be charged a $20.00 no show/no cancellation fee.

CONFIDENTIALITY: All sessions with your therapist are confidential. No information will be released without your written consent. However, there are some exceptions including, but not limited to the following:

1. All insurance companies require that a provider furnish a diagnosis and sometimes a treatment plan on each client in order to justify the necessity of treatment and payment. Your insurance company paying for services may have a right to review all of your treatment records.
2. Missouri State Law demands that all providers report any suspected physical or sexual abuse to the appropriate Child or Elderly Hotline Services, which is then reported to the appropriate agency for investigation.
3. Missouri State Law and Professional Ethics require all providers to report if a client is homicidal or suicidal. This is reported in order to help the client rather than harm the client. Therapist also has a duty to warn any person who is a potential target for harm by a client. Therapist will notify targeted person and law enforcement of any such threats.
4. If a Federal or State Court requests the release of records, the provider has to comply, with certain exceptions.
5. Most insurance companies require that a provider keep a patient's "Primary Care Physician" informed of his/her mental health treatment. By signing the consent, you agree to allow me to keep your physician informed at my discretion.
6. A fee dispute between the therapist and client.
7. A negligence suit brought by the client against the therapist or a complaint filed with a licensing board, or other state or federal regulatory authority.

For further information, please review the Notice of Privacy Practices handout provided to you by the therapist. If you have additional questions, please address them with the therapist. By signing this information and consent form, you are giving consent to the understated therapist to share confidential information with all persons mandated by law and with the managed care company and/or insurance carrier responsible for providing your mental health services and payment for those services. You are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

DUTY TO WARN

I designate the following people to be contacted if I am in danger:

NAME TELEPHONE NUMBER RELATIONSHIP

_____

_____

_____

FINANCIAL POLICY

The initial therapy session is billed at $120 a session. All following sessions are billed at $100 per session. **All payments and co-payments MUST be paid at the time of service.** For your convenience, I accept cash, checks, MasterCard, Discover, and Visa. Returned checks will have a $25 fee. If there are questions or concerns about the therapy fee, please discuss this matter with me.

CREDIT CARD AUTHORIZATION

I, _____ authorize Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, to charge my credit card for any balances on my account, to also include copays if not paid via cash, check or Venmo. In the event that I do not cancel an appointment within 24 hours and my appointment cannot be rescheduled that same week, I authorize that my credit card be charged a $20 cancellation fee.

Name of Credit Card Holder:		Billing Zip Code:
Credit Card #:	Exp Date:	CVV2:

_____ _____

Client Signature Date

_____ _____

Responsible Party if other than client Date

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services described above, for the amount indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

PATIENTS

Clients are not discriminated against in the delivery of healthcare services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment. Clients will be given a referral if the clinician deems the patient's needed treatment is beyond her area of expertise and experience.

ADULT PATIENTS

Adult patients are responsible for payment of their own accounts.

MINOR PATIENTS

The adult accompanying a minor and the parents/guardians of the minor are responsible for payment of the minor's account.

DOCUMENTATION

I **do <u>not</u>** provide written documentation, summaries or completion of forms requested by you or other agencies (i.e. Social Security Administration, short-term disability companies, etc.). However, if any formal request for this service is requested, a fee of $50.00 per document will be charged to the client. The fee will be collected from the client prior to the completion of the document.

LEGAL PROCEEDINGS

The therapist does <u>not</u> attend court proceedings. If you believe any situation you are involved in will require the therapist being involved in legal matters, a referral to other therapists will be provided to you. If the therapist is subpoenaed on your behalf or if for testimony on behalf of another party which involves you, a fee of $200/hour will be charged for the

therapist's time, preparation and expense spent in responding to a subpoena. This fee also applies to travel time and time spent in court. This fee will be charged from when the therapist leaves her residence, the duration of court proceedings and until the time the therapist returns to her residence. You will be required to pay the estimated fee prior to the court date. Any amount collected in excess of the actual time spent will be refunded to you.

TELEPHONE CONCERNS AND AFTER HOURS CONTACT

Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, RPT, can be reached via phone at (314) 744-9253. If a call involves therapy discussions via telephone, the client and not the insurance company, will be charged. A discussion of 30 minutes and over will be billed for a full session. A telephone call to schedule, cancel, or change an appointment will not be charged.

Clients are assumed to be self-responsible and autonomous and not in need of day-to-day supervision. Therefore, I cannot assume responsibility for day-to-day functioning as can an institution (hospital, mental health agency). In order for me to provide the best care for my clients, if you believe you are in a life threatening crisis, please call 911, call your psychiatrist, go to the nearest emergency room, and call Life Crisis 314-647-4357 or Behavior Health Response (BHR) at 314-469-6644. Please leave a message at (314)744-9253 if you need to cancel an appointment.

THERAPIST'S INCAPACITY OR DEATH

In the event Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, RPT, is unable to continue facilitating therapy sessions, due to her illness, death, or other emergency situation, it will be necessary for another mental health professional to take possession of my file and records and access to my contact and treatment information. I give permission to allow Julia Dooley, LPC, RPT, to take possession of my file and records. I am aware that I may have a copy of portions of the file or request that it be transferred to a mental health professional of my choosing.

CONSENT TO TREATMENT

I voluntarily agree to receive mental health services which include assessment, care, treatment or services through the understated therapist.

I agree to participate in the planning of my care, treatment or services and I acknowledge that I may discontinue care, treatment or services at any time.

I have thoroughly read and understand this Client Information and Consent Form. I agree to all the terms and information contained in this document. I have been given opportunity to ask questions and seek clarification of this document. I acknowledge that I have been given the choice to receive a copy of this signed Client Information & Consent Form. I understand my rights related to my Protected Health Information.

1)_____ _____

Client Signature Date

2) _____ _____

Client Signature Date

_____ _____

Responsible Party if other than client Date

_____ _____

Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, RPT Date

❑ Client received a copy ❑ Client declined a copy

Notice of Privacy Practices
Carissa Rupp, MA, PLPC
under the supervision of Julia Dooley, MA, LPC, RPT (Effective
April 15, 2003; amended August 1, 2013)
This notice is developed in compliance with the Health Insurance Portability and Accountability Act of 1996 (45CRF)

Carissa Rupp, Master of Arts (MA), PLPC (Provisionally Licensed Professional Counselor), Supervised by Julia Dooley, MA (Master of Arts), Licensed Professional Counselor (LPC) this notice describes how your health information may be used and disclosed and how you can get access to this information. Please review this notice carefully.

I. Understanding Your Health Record/Information

As a client of Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, a record is kept of your visit. This record contains your reason for seeking services, symptoms, diagnosis, and a plan of treatment for future services. Although this record is the property of Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, the information within the record belongs to you. This information is considered your "Protected Health Information" (PHI) and is afforded certain protections under the law.

II. HITECH Amendments: Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, has included HITECH Act provision to its Notice as follows: HITECH Notification Requirements. Under HITECH, Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, is required to notify clients whose PHI has been breached. Notification must occur by first-class mail within sixty (60) days of the event. A breach means the acquisition, access, use or disclosure of PHI in a manner not permitted under the Privacy Rule which compromises the security or privacy of such information. This Notice must: (1) contain a brief description of what happened, including the date of the breach and the date of discovery; (2) the steps the individual should take to protect themselves from potential harm resulting from the breach; and (3) a brief description of what Carissa Rupp is doing to investigate the breach, mitigate losses, and to protect against further breaches.

Cash Clients

HITECH provides, that is a client pays in full for their services out of pocket, they can demand that the information regarding the service not be disclosed to the client's health plan since no claim is being made to the health plan.

Access to E-Health Records

HITECH expands this right, giving individuals the right to access their own e-health record in electronic format, and to direct Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, to send the e-health record directly to a third party. Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, may only charge for labor costs under these new rules. Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, currently does not participate in EHealth Records, when this becomes an option, all clients will be notified.

III. How I May Use and Disclose Your Protected Health Information

Carissa Rupp, MA, PLPC, Supervised by Julia Dooley, MA, LPC, will not disclose your health information without your authorization, except as described in this notice.

Other

Walter's Walk: Carissa Rupp, MA, PLPC,, Supervised by Julia Dooley, MA, LPC, may also provide your contact information (name, address and phone number) to Walter's Walk, which handles fundraising efforts. However, you may opt out from these efforts. To opt out, please notify Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC.

Treatment: Carissa Rupp, MA, PLPC, Supervised by Julia Dooley, MA, LPC, will use your health information to provide treatment. For example, information obtained will be recorded in your record and used to determine the course of treatment/services. Carissa Rupp, MA, PLPC , supervised by Julia Dooley, MA, LPC, may consult with other health care professionals to coordinate treatment/services. This will only be done to ensure the course of treatment/services is appropriate to your situation.

Payment: Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, will use your health information to receive payment for services rendered. For example, Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, may release portions of your health information to an insurance plan or other payer in order to receive payment for services provided to you.

Health Care Operations: Your health information may be reviewed by regulatory and accrediting organizations to ensure compliance with their requirements.

When Required by Law: Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, may disclose your health information when a law requires that the therapist report information about suspected abuse, neglect, domestic violence, relating to suspected criminal activity, or in response to a court order.

Duty to Warn: Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, may disclose protected health information when a client communicates to her a serious threat of suicide or physical violence against himself, herself or a reasonably identifiable victim(s). In such an instance, Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, will notify either the threatened person(s) and/or law enforcement.

Notification: In an emergency, Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, may use or disclose health information to notify or assist in notifying a family member, personal representative or another person responsible for your care, of your location and general condition.
Workers Compensation: Carissa Rupp, MA, PLPC,, supervised by Julia Dooley, MA, LPC, may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker/s compensation or other similar programs established by the law.

Public Health: As required by federal and state law, Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Correctional Institution: Should you be an inmate of a correctional institution, Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, may disclose to the institution health information necessary for your health and the health and safety of others.

Charges Against Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC: Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, may disclose your health information to defend herself against any legal action you may take against her.

Appointments/Treatment: Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, may contact you about appointment reminders or treatment alternatives.

In all of the above stated circumstances, other than for treatment, Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, will release only the minimum amount of information necessary to accomplish the purpose of the use or disclosure.

Other:
In any other situation, Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, will request your written authorization before using or disclosing any of your identifiable health information. For instance, most uses and disclosures of psychotherapy notes (if recorded by therapist) and most uses and disclosures for marketing purposes, including subsidized treatment communications, will require your authorization. Additionally, most disclosures of PHI that constitute the sale of PHI will require your authorization. If you choose to sign such an authorization to disclose information, you can revoke that authorization at any time to stop future uses/disclosures.

IV. Your Rights Regarding Your Health Information

You have the following rights with respect to your protected health information:

1. You have the right to request in writing that your protected health information not be used or disclosed by Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, for treatment, payment or administrative purposes or by to persons involved in your care except when specifically authorized by you. Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, will consider the request, but is not legally bound to agree to the restriction unless it pertains to disclosures to a client's health plan concerning an item or service for which Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, has been paid out-of-pocket in full. To the extent that she does agree with any restriction, she will put the agreement in writing and abide by it except in emergency situations. She cannot agree to limit uses/disclosures that are required by law.
2. You have the right to request that Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, or send you information at an alternative address or by an alternative means. She will agree to your request as long as it is reasonably easy for her to do so.
3. You have the right, within the limits of Missouri statutes, to inspect and copy your protected health information. Any such requests must be made in writing. Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, will respond in writing to such a request within 30 days. If you request copies, Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, may charge you a reasonable cost for copying.
4. You have the right to submit a request to amend your information if you believe that information in your record is incorrect or if important information is missing.
5. You have the right to receive an accounting of certain disclosures of your protected health information.
6. You have a right to receive this Notice in paper and/or in electronic format.

V. Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, Duties:

1. Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.
2. Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, is required to abide by the terms of this Notice currently in effect, and
3. Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, reserves the right to change the terms of this Notice and make the new Notice provisions effective for all protected health information that she maintains. Should Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC make changes in its Notice, she will post the changed Notice in the office waiting area. You may request a copy of the Notice at any time.

VI. Complaint Procedure

If you are concerned Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, has violated your privacy rights, please contact her. You have the right to file a complaint with her or with the Board of Walter's Walk and/or with the Secretary of the Federal Department of Health and Human Services. Under no circumstances will any action be taken against you for filing a complaint.

By signature, I confirm that I have received this Notice relative to the use of my protected health information.

_____ _____

Client or Guardian Signature **Date**

❒ **Client received a copy** ❒ **Client declined a copy**

_____ _____

Signature of Professional **Date**

Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC
737 Dunn Road
Hazelwood, MO 63042
314-744-9253

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, invited me to engage in a telehealth consultation.
2. Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client visit due to the fact that I will not be in the same room as she.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, during which I had the opportunity to ask questions in regard to this process. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language which I understand.

CONSENT TO USE TELEHEALTH OPTION

Telehealth through Doxy.me, Zoom, or GoogleMeet is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by Doxy.me, Zoom, or GoogleMeet is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, and I may be in direct, virtual contact through this Telehealth Service, neither provide any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by Doxy.me, Zoom, or GoogleMeet facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, has access to any or all of the technical information in the Telehealth by Doxy.me, Zoom, or GoogleMeet – or that such information is current, accurate or up-to-date. I will not rely on Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC, have any of this information in the Telehealth by Doxy.me or Zoom.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment. By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ _____

Signature Date

Email to: carissamrupp@gmail.com or mail to:
Carissa Rupp, MA, PLPC, supervised by Julia Dooley, MA, LPC
737 Dunn Road
Hazelwood, MO 63042