Tensegrity
COUNSELING ASSOCIATES

Jacquelyn "Jackson" Tecmire, M.S., LMFT
1733 W 33rd St., Suite 120, Edmond, OK 73013
Phone: (405) 285-7332 Fax: (405) 285-7338

CONSENT FOR TREATMENT & POLICIES

Welcome! I am honored that you chose me to provide your individual, couples, or family therapy services. My mission is to provide you with quality care that fits your needs. It is my belief that every person is unique and deserves a customized treatment plan. I am willing to incorporate the therapy techniques that meet your specific needs. I am also committed to adhering to guidelines that protect you as my client. As a result, I would like for you to be aware of the following guidelines before your mental health and/or addiction treatment with me begins.

Confidentiality:

Your verbal communication and clinical records are strictly confidential except for:
a) Information (diagnosis and dates of service) shared with your insurance company to process your claims;
b) Information you and/or your child(ren) report about physical or sexual abuse; then, by Oklahoma state law, I am obligated to report this to the Department of Human Services;
c) Where you sign a release of information to have specific information shared;
d) If you provide information that informs me that you are in danger of harming yourself or others;
(e) Information necessary for case supervision or consultation;
(f) When required by law.

A transfer plan is in place in the unlikely event that I am unable to provide ongoing services. Your records will be maintained by the backup therapist for a period of 7 years.

CLIENT INITIALS: _____

Emergency Services:

Tensegrity Counseling Associates is not an emergency service. If an emergency for which the client or their guardian feels immediate attention is necessary and I am unable to return your call within a reasonable amount of time, the client or guardian understands that they are to contact 911, go to the nearest emergency room for those services, contact the Crisis Center at (405) 522-8100, or call the Suicide Prevention Hotline at 1-800-784-2433.

CLIENT INITIALS: _____

Financial & Insurance Issues:

As a courtesy, I will bill your third-party payer, responsible party or insurance company. If a third-party is paying for your services, you will need to sign a release giving me permission to discuss financial matters relating to your treatment services with the third-party. Additionally, the third-party will need to make financial arrangements directly with the office manager. **Payment in full is required at each session**.

CLIENT INITIALS: _____

Canceling or Rescheduling Appointments:

Your time is extremely valuable. Every effort is made to ensure that your session is productive and uninterrupted. If you are unable to keep your appointment, please give a 24-hour notice of cancelation so that you will not be assessed the **$125 fee**. Often there are others that would like to fill your session time in the event you cannot keep your appointment. I appreciate your cooperation in trying to provide high quality service.

CLIENT INITIALS: _____

Involvement in Legal Matters:

My services **do not** include court related work, testifying, depositions, child custody disputes, reports or letters written to the judge, or discussing matters with your attorney. If I am forced to provide such services my court fees will apply (please see the fees page) and you will be required to pay in advance.

CLIENT INITIALS: _____

Professional Consultation:

As a therapist, it is helpful to consult with a professional colleague regarding treatment issues that arise with my clients. All mental health professionals are bound by confidentiality laws as well as a code of ethics. If you have an issue with this, please speak to me about it so that we can discuss it together.

CLIENT INITIALS: _____

Couples & Family Counseling:

Working with couples and families is different than individual therapy. All members of the session are considered "the client" together as a unit and are entitled to rights of informed consent and confidentiality. This means that all persons with legal status would have to sign a release of information before any information could be released outside of the system. I may on occasion meet with people individually as needed for supportive purposes for the greater good of the family or couple unit, but I adhere to a strict "no secrets policy". While it is not my practice to reveal information from individual sessions, I also cannot guarantee complete confidentiality as the issues overlap. If you are concerned about details that need to be kept secret, then it will be important for you to have your own individual therapist separate from my services.

CLIENT INITIALS: _____

No Secrets Policy:

I view the client, couple, and/or family as a unit of treatment. Therefore, it is my practice to adhere to a "no secrets" policy in our work together. This means that I may choose not to partake in keeping secrets from members of the therapeutic system. If you are participating in couple's or family therapy, any information you disclose to your therapist may be openly discussed with other participating parties as part of treatment.

Therefore, if you have secrets to keep from the other members of the therapy process you will need to do so in an individual therapy setting with a separate therapist. If you need assistance finding an individual therapist please let me know and I will give you some referrals.

CLIENT INITIALS: _____

Photography of Client/Artwork/ Creations:

I give my permission for the therapist to photograph the client's artwork/creation if requested by the client. These photos will be shared with the client or parent and will become part of the client record.

CLIENT INITIALS: ____

Progress During Treatment:

Making progress and meeting your treatment goals are important. If at any point, you do not feel like you are making the progress you want or you feel like we are not a good match for each other please let me know. I want you to feel like you are getting what you need out of our time together. I will not take it personally if you feel like you need to work with another therapist, want to change the direction of treatment, or want to change your treatment goals. I am open to discussing these things at any time. If you need help finding a therapist more compatible with your needs I would be happy to provide you with contact information of other therapists I know.

CLIENT INITIALS: _____

Telemedicine Services:

I have agreed to participate as a client on the https://www.gotomeeting.com telemedicine network. I will be receiving health care services through interactive video and/or camera equipment. I understand that, at this time, there are no known risks involved with receiving my care in this way. I understand my participation in this is totally voluntary and I may decide to quit at any time. My privacy and confidentiality will be protected at all times. I understand that my provider will deliver telemedicine services from a secure location that safeguards my confidentiality. I understand that it is my responsibility to select a safe and secure location to receive telemedicine services. I give my consent to receive services over the videoconferencing and/or camera equipment. I understand the services I receive will become part of my treatment record. I have read this document and I hereby consent to participate in telemedicine network under the terms described above.

CLIENT INITIALS: _____

If you have questions regarding your care, please let me know. Any non-emergency phone messages will be returned as scheduling allows, but primarily will be returned at the end of the day.

I have read and understand the **Consent for Treatment. By signing below, I certify that I agree to these guidelines as defined above.

Signature: _____ Date: _____

Printed Name: _____

I also certify that I have received a copy of the **Notice of Privacy Practices detailing the provisions of HIPAA and my privacy rights.

Signature: _____ Date: _____

Printed Name: _____

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INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

If you choose to meet in person for some or all future sessions, please keep in mind that if there is a resurgence of the pandemic or if other health concerns arise, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law. If your insurance does not cover telehealth you will be responsible for the full cost of the session.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the potential risk of exposure to the coronavirus (or other public health risk).

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [my other staff] and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free. ___
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee. ___
- You will wait in your car or outside until no earlier than 5-10 minutes before our appointment time. I will come to the door and let you in at the appointment time. ___

- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. ___
- If you want me to wear a mask in our therapy sessions you will let me know. ___
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me [or staff]. ___
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. ___
- You will take steps between appointments to minimize your exposure to COVID. ___
- If you have a job that exposes you to other people who are infected, you will immediately let me [and my staff] know. ___
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and my staff] know. ___
- If a resident of your home tests positive for the infection, you will immediately let me [and my staff] know and we will then [begin] resume treatment via telehealth. ___

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the coronavirus within the office. Please let me know if you have questions about these efforts.

If You or I Are Sick

You understand that I am committed to keeping you, me, [my staff] and all of our families safe from the spread of this virus. If you show up for an appointment and I [or my office staff] believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I [or my staff] test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details 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 signature below shows that you agree to these terms and conditions.

Client Signature _____ Date_____

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SOCIAL MEDIA POLICY

Email
Please use email to contact me for administrative reasons only (modifying appointments, billing information, etc.). Please do not email content related to our counseling sessions, unless otherwise discussed. Email communication is not completely secure or confidential. Any emails I receive from you and any responses I send to you become a part of your legal record.

Text Messages
Please do not send text messages, unless otherwise agreed upon. I will not respond to texting. Any text message I receive from you becomes a part of your legal record.

Friending
I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). Adding clients as friends on these sites can compromise your confidentiality and our therapeutic relationship.

Following
I will not follow any client on Twitter, Instagram, blogs, or other apps/websites. If there is content you wish to share from your online life, please bring it into our sessions where we can explore it together.

Search Engines
It is not a regular part of my practice to search for clients on Google, Facebook, or other searchable sites. An exception could be during a crisis. If I have reason to suspect you are a danger to yourself or others and I have exhausted all other reasonable means to contact you and/or your emergency contact, then I may use a search engine for information to ensure your welfare. If this ever occurs, I will fully document the search and discuss it with you at your next session.

Location-Based Services
Please be aware if you use location-based services on your mobile phone you may compromise your privacy while attending session at my office. My office is not a check-in location on various sites such as Foursquare, however it can be found as a Google location. Enabled GPS tracking makes it possible for others to surmise you are a counseling client due to regular check-ins at my office location.

Business Review Sites

You may find my psychology practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client.

I have read and understand the **Social Media Policy. By signing below, I certify that I agree to these guidelines as defined above.

Signature: _____ Date: _____

Printed Name: _____

STATEMENT OF PROFESSIONAL DISCLOSURE

This document is to inform you about my professional training, orientation/techniques, experience, fees, and credentials. I am a Licensed Marital and Family Therapist (LMFT) by the Oklahoma State Department of Health, license number 1130

The licensing website is listed below where you can access the law and regulations which govern my license. I will furnish you with printed materials about the requirements of my licensure if you so desire. You may contact, without giving your name, the licensing boards at:

State Board of Behavioral Health Licensure

3815 N. Santa Fe, Ste. 110

Oklahoma City, OK 73118

Telephone: (405) 522-3696

Fax: (405) 522-3691

www.ok.gov/behavioralhealth

Jackson Tecmire, M.S., LMFT has satisfactorily supplied me with information regarding her practice, licensure, and professional development.

*Signature of Patient/Parent/Guardian*_____ *Date*_____

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FEES FOR SERVICES

Individual Therapy per hour	$150
Missed Appointment/No Show/Late Cancelation fee	$125
Returned checks	$30

Telephone discussions longer than 5 minutes and the preparation of reports will be charged according to my hourly rate prorated according to the amount of time spent.

Court Fees:

The following fees will be assessed to you, the client or client's guardian, if I must appear in court for any reason, under any and all circumstances, relating to the client or client's family.

➢ Travel time per 15 miles	$120
➢ Court appearance *(minimum of 4 hours including commute & waiting)	$1200
➢ Each additional hour for court appearance	$300
➢ Preparation of reports for court (per 15 minutes)	$75
➢ Emergency appearance (less than 14 days' notice)	$400/hr.

***Appearance must be scheduled at least 14 days in advance. Court fee is due at the time of scheduling the appearance and is non-refundable without a 7-day notice for cancellation. These fees are subject to change without notice.**

I hereby acknowledge that these services are not a benefit of my health coverage and I will be personally responsible for the payment in full of the billed charges for these services.

Signature: _____ Date: _____

Printed Name: _____

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APPOINTMENT REMINDERS

As a courtesy, we offer automated appointment reminders. Please indicate below how you would like to receive reminders. Please just choose one.

Your name: _____

- ❑ Via a text message on my cell phone (normal text message rates will apply)

  Cell # _____

- ❑ Via an email message to the address listed here

  Email address _____

- ❑ Via an automated telephone message to my home phone

  Home # _____

- ❑ None of the above. I'll remember my appointments on my own. **(Missed appointment fees will still apply)**

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

Signature: _____ Date: _____

Printed Name: _____

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Patient Name_____

My credit card / debit information will be entered and saved in the HIPPA-secure Ivy Pay (Ivy Labs, Inc.) credit / debit card option. I authorize Tensegrity Counseling Associates to use my credit card details for charges incurred for: _____ (Patient Name), which includes fees for services and missed session fees ($125). I understand that I will receive a notification / receipt when there is a transaction through Ivy Pay.

This agreement will remain in effect until I revoke this agreement in writing to: Tensegrity Counseling Associates, 1733 W 33rd St., Suite 120, Edmond, OK 73013.

I understand that if the client's fees for services / missed session fees are not paid as agreed it will be turned over for outside collections and all collection agency's fees and attorney's fees will become patient responsibility

_____ _____

Responsible Party Signature Date

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Client Information Form

Name: _____Age: _____ Date: _____

Street Address: _____Suite/Apt. #: _____

City: _____ State: ____ Zip Code: _____

May we send mail here? ☐ Yes ☐ No

Date of Birth: _____ Sex: ☐ Male ☐ Female

Parent/Guardian: _____ Relationship: _____

How did you find out about my services? ☐ Psychology Today ☐ Facebook

☐LinkedIn ☐ Webpage ☐ Person: _____

Contact Information:

Home #: _____OK to leave message? ☐Yes ☐No

Work #: _____ OK to leave message? ☐Yes ☐No

Cell #: _____ OK to leave message? ☐Yes ☐No

Email: _____ OK to email you? ☐Yes ☐No

Emergency Contact:

Name: _____ Relationship to you: _____

Address: _____

Phone #: _____

Insurance Information:

Primary Insurance: _____ Member ID#:_____

Policy Holder Name: _____Policy Holder Birthdate: _____

Is there anyone you want to grant permission to discuss with the therapist information relating to the client's treatment plan? If so, please list their name and relationship to the client.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Work/School Information:

If student, which school attending? _____

What grade? _____

Demographic Information:

Ethnic/Racial background: _____

Sexual Orientation:_____

Religious/Spiritual background: _____

Involvement in religious/spiritual activities: ☐ none ☐ some/irregular ☐ active

With whom does the client currently live? Please list their names, ages, and relationship to you.

Name: _____Age: _____ Relationship: _____

Name: _____Age: _____ Relationship: _____

Name: _____Age: _____ Relationship: _____

Name: _____Age: _____ Relationship: _____

Name: _____Age: _____ Relationship: _____

Name: _____Age: _____ Relationship: _____

Health Background:

List all current medications and dosages, including supplements:

Name	Dose	How often	Reason	Date Started	Prescribing Dr.

Are these medications taken according to doctor's recommendations? ☐ Yes ☐ No
Does your child take vitamins? ☐ Yes ☐ No

List all hospitalizations, severe injuries, head injuries that involved loss of consciousness, and current as well as past health problems:

Health Problem/Injury/Operation	Date	Currently a problem?

List any allergies your child has: _____

Approximate date of child's most recent physical examination: _____
Was blood taken? ☐ Yes ☐ No

Women: # Pregnancies _____# Births _____ # Abortions _____ # Miscarriages ____

List any addiction/substance abuse treatment or psychiatric treatment and dates:

Name of Treatment or Psychiatric Facility	Dates	Inpatient/Outpatient

Does your child show unusual behavior (explain)? _____
_____
_____
_____
_____
_____

If school age, what does your child's teacher say about him/her? _____

_____
_____
_____
_____

Other Information: _____
_____
_____
_____
_____
_____

Please indicate if you have ever experienced any of the following:

Historical Information	Yes	No
Has the child ever been in legal trouble?		
Is there a history of mental health problems, suicides, or suicide attempts in your family?		
Has the child ever been physically abused?		
Has the child ever been emotionally abused?		
Has the child ever been verbally abused?		
Has the child ever been sexually abused or sexually assaulted?		
Has the child ever witnessed violence or a tragic event?		
Has the child ever attempted suicide?		
Has the child ever put herself/himself in harmful situations?		
Has the child ever injured herself/himself?		
Has the child ever acted out sexually?		
Has the child ever wanted to severely hurt or kill someone else?		
Has the child ever acted aggressively towards others?		
Is there a history of drug or alcohol problems in the family?		
Does the child currently use alcohol?		
Does the child currently use street drugs?		
Does the child currently use tobacco?		
Does the child currently use medicines that are not prescribed?		

Symptom	Past	Present	Symptom	Past	Present
Fighting			Self harm/cutting		
School suspension			Bed wetting		
School expulsion			Going to the bathroom in pants during the day		
Lack of friends			Acting out sexually		
Learning disabilities			Chronic lying		
Incomplete homework			Stealing		
Alcohol or other drug use			Trouble with authority figures		
Skipping class			Trouble specifically with male adults		
Difficulty concentrating or focusing			Trouble specifically with female adults		
Gang influence			Overly sensitive		
Poor attendance			Crying episodes		
Behavior problems			Difficult to console when upset		
School detention			Socially awkward		
Poor grades			Withdrawn from others		
Conflicts with teachers			Chronic sadness		
Conflicts with peers			Angry outbursts		
Eating more			Excessive worry or fear		
Eating less			Impulsive		
Binge eating			Fire setting		
Purging after eating			Cruelty to animals		
Self starvation			Exposure to pornography		
Sneaking food			Grief/Loss		
Weight loss			Parent-child relationship issues		
Weight gain			Disaster		
Sleeping too little/too much			Headaches		
Difficulty falling asleep			Intestinal trouble		
Insomnia			Fatigue		
Wakefulness			Trouble relaxing		
Nightmares			Body pain		
Teeth grinding			Stomach problems		
Jaw clenching			Weakness		
Pornography use			Tiredness		
Compulsive masturbation					