



COBYS Family Services  
1417 Oregon Rd, Leola, PA 17540  
Phone: 717-661-3548  
Fax: 717-656-3056 · Web: [www.cobys.org](http://www.cobys.org)

## Adult Intake Information

Welcome to COBYS Family Services. We are pleased to have the opportunity to serve you. Please complete this form. The following information will assist the counselor and you to work together. This information is confidential and will not be shared without your permission.

**Identified Client:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Email Address: \_\_\_\_\_ Home Telephone: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Home Address: \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Marital Status: Married \_\_\_\_\_ Divorced \_\_\_\_\_ Single \_\_\_\_\_ Separated \_\_\_\_\_ Cohabitated \_\_\_\_\_

Attend school? Full-time \_\_\_\_\_ Part-time \_\_\_\_\_ No \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Work Telephone: \_\_\_\_\_ Ext \_\_\_\_\_

Are you or anyone in your family involved in any way with the legal system? (probation, custody, protective services, etc.)

Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, please explain: \_\_\_\_\_

Religion/Church affiliation (place of worship/location/denomination): \_\_\_\_\_

What are some of your strengths? \_\_\_\_\_

### Medical Information:

Physician's Name/Practice: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Approximately when was your last visit to your doctor or practitioner? \_\_\_\_\_

Do you give COBYS permission to contact your physician concerning treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

Signature (may sign electronically): \_\_\_\_\_

Do you have any allergies, including allergies to medications? \_\_\_\_\_

List current or recent medications:

Name	Amount	How Often	Purpose

Have you or anyone in your family ever received psychiatric or psychological help of any kind? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

### Referral Information (please check one from the list):

How did you learn about COBYS Family Services? Brochure/Flyer/Pamphlet \_\_\_\_\_ Church \_\_\_\_\_ Former Client \_\_\_\_\_ Pastor \_\_\_\_\_  
Yellow Pages \_\_\_\_\_ Newspaper \_\_\_\_\_ Internet \_\_\_\_\_ Friend/Family \_\_\_\_\_ Other (please specify) \_\_\_\_\_

Who referred you for counseling services at the center? \_\_\_\_\_

Briefly describe your reason for seeking help: \_\_\_\_\_



COBYS Family Services  
1417 Oregon Rd, Leola, PA 17540  
Phone: 717-661-3548  
Fax: 717-656-3056 · Web: [www.cobys.org](http://www.cobys.org)

## Adult History Form

Welcome to COBYS Family Services. We are pleased to have the opportunity to serve you. Please complete this form. The following information will assist the counselor and you to work together. This information is confidential and will not be shared without your permission.

Identified Client: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Education Level: Elementary      Middle School      High School      Trade School      College      Post-Graduate

### **Family**

Please list the names of all persons living in your household:

Name	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please provide information about children not currently living with you.

\_\_\_\_\_  
\_\_\_\_\_

Are you currently married or living with someone in a committed relationship? \_\_\_\_\_ If yes, please complete the following:

1. How long have you been married or in this relationship? \_\_\_\_\_
2. What is the person's age? \_\_\_\_\_ Occupation? \_\_\_\_\_
3. Describe his/her personality: \_\_\_\_\_
4. In what areas do you agree? \_\_\_\_\_
5. In what areas do you disagree? \_\_\_\_\_

Provide any relevant information regarding abortions or miscarriages.

Please provide information about your marital/divorce history. Give dates of when you were in these relationships and state whether or not you obtained a divorce:

What was the impact of the loss of the relationship on your mood/functioning/etc:

Have you ever been a victim of sexual abuse \_\_\_\_\_, physical abuse \_\_\_\_\_, and/or emotional abuse \_\_\_\_\_?

## Family of Origin

Please complete the following about your family of origin. Indicate if full, half, or step.

Siblings: Number of brothers? \_\_\_\_\_ Their ages: \_\_\_\_\_

Number of sisters? \_\_\_\_\_ Their ages: \_\_\_\_\_

Father: Living \_\_\_\_\_ Deceased \_\_\_\_\_ If alive, give father's present age: \_\_\_\_\_

Occupation: \_\_\_\_\_ If deceased, how old was he at time of death? \_\_\_\_\_

How old were you at the time? \_\_\_\_\_ Cause of death: \_\_\_\_\_

Mother: Living \_\_\_\_\_ Deceased \_\_\_\_\_ If alive, give mother's present age: \_\_\_\_\_

Occupation: \_\_\_\_\_ If deceased, how old was she at time of death? \_\_\_\_\_

How old were you at the time? \_\_\_\_\_ Cause of death: \_\_\_\_\_

If you were not continuously brought up by your parents, who raised you and between what years?

If you have a stepparent, give your age when parents remarried: \_\_\_\_\_

Give a description of your father's (or male caregiver's) personality and his attitude towards you (past and present):

Give a description of your mother's (or female caregiver's) personality and her attitude towards you (past and present):

In what ways were you disciplined (punished) by your parents as a child?

Give an impression of your home atmosphere where you grew up. Mention state of relationship between parents and between children:

Were you able to confide in your parents?

As a child, did you experience any of the following?

Feeling secure      Examples of forgiveness      Feeling loved      Examples of good values

Feeling valuable      Feeling warmth and acceptance

What did you feel you received from your father?

Are there things you wish you would have had from him?

What did you feel you received from your mother?

Are there things you wish you would have had from her?

As a child, did you experience any of the following?

Long separation from a parent      Serious illness or accident      Frequent family moves

Domestic violence in family      Significant loss (someone close to you dying or moving away)

Parental substance abuse      Other family or individual stressor: \_\_\_\_\_

## Mental Health

Have you ever been in counseling or received any form of professional help for your problems? Yes      No

If yes, please provide dates, therapists' names, and length of treatment:

Dates	Therapist Name	Length of Treatment

What was helpful in previous counseling or treatment?

Any history of psychiatric hospitalizations? (dates and reasons)

Any history of traumatic experiences of any nature? (natural disasters, abuse, accidents)

List three things you worry about or are concerned about:

- 1.
- 2.
- 3.

When do you feel the most calm and relaxed?

How do you like to feel?

What do you imagine your life looking like when the problem that brought you here is taken care of?

Please describe the impact caused by any loss of previous relationships on your mood and functioning.

Is there anything else regarding what you have been experiencing that you want your therapist to know?

## Alcohol, Tobacco and Drug History

Please complete the following chart.

	Do you currently use this substance?	Age Range (when you used the substance)	Quantity (how much of the substance you use/used at a time)	Frequency (how often you use/used the substance)
Alcohol (beer, wine, liquor)				
Marijuana, hashish				
Tobacco (cigarettes, snuff, chew)				
Caffeine (coffee, tea, soda, energy drinks)				
Hallucinogens (LSD, mushrooms, peyote etc.)				
Depressants (Xanax, Valium, barbiturates etc.)				
Stimulants (speed, cocaine, ecstasy, ephedrine, etc.)				
Inhalants (glue, gasoline, Pam, etc.)				
Opiates (heroin, Vicodin, Codeine, OxyContin, Percodan etc.)				

Other addictive/time consuming activities (gambling, pornography, eating, etc):

## Spiritual/Religious/Faith/Culture

Do you believe in God? Yes                  No

How important is your religious/faith/spiritual life?

Describe your spiritual life practices:

How would you like to include your spiritual/religious/faith into your treatment?

Describe your culture:

How would you like to include your culture into your treatment?

## Symptom Checklist

**Check any of the following behaviors/emotions that apply to you:**

Agitation or irritability	Aggressive behavior	Angry outbursts	Binge eating
Crying	Delusions	Drink too much	Fatigue
Feeling anxious	Feeling depressed	Feeling guilty	Feeling worthless
Hallucinations	Impulsiveness	Isolation	Lack of motivation
Loss of control	Loss of interest/pleasure in life	Panic attacks	Period of time with extreme focus
Phobias	Procrastination	Purging	Repetitive behavior
Restricted eating	Take too many risks	Thoughts of death	Thoughts of suicide/self-harm
Unusually high energy	Work too hard	Other _____	

**Any changes in:**      Increase      Decrease

Weight/appetite  
Sex drive/desire  
Short term memory  
Ability to concentrate  
Sleep habits

**Check any of the following physical sensations that apply to you:**

Aches/Pains	Back pain	Blackouts	Bowel disturbances	Burning or itchy skin
Chest pains	Dizziness	Don't like to be touched	Dry mouth	Excessive sweating
Fainting spells	Flushes	Headaches	Hearing problems	Hearing things
Muscle spasms	Numbness	Palpitations	Rapid heart beat	Skin problems
Stomach trouble	Tension	Tics	Tingling	Tremors
Twitches	Unable to relax	Visual disturbances	Other _____	

**Check any of the following that apply to you or members of your family:**

Self	Family	Self	Family	Self	Family
Allergies		Arthritis		Asthma	
Cancer		Diabetes		Epilepsy	
Gastrointestinal disease		Glaucoma		Heart disease	
High blood pressure		Infectious disease		Infertility	
Kidney disease		Neurological disease		Prostate disease	
				Thyroid disease	

**Injuries/Accidents:**

Have you ever had a head injury or loss of consciousness? Please give details:

Please describe any surgeries you have had (give dates).

Please describe any accidents or injuries you have suffered (give dates).

Have you ever engaged in self-harm behaviors to any part of your own body, such as cutting, scratching, picking, burning, etc.? Please give details.



COBYS Family Services  
1417 Oregon Rd., Leola, PA 17540  
Phone: 717-661-3548  
Fax: 717-656-3056 · Web: [www.cobys.org](http://www.cobys.org)

## **Brief Notice of Privacy Practices (NPP)**

This information is being provided to you as required by the Health Insurance Portability and Accountability Act of 1996. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

### **COBYS Family Services' commitment to your privacy:**

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This notice is a shorter version of the full version. It summarizes the main points of the policy. We are required to give every client of the counseling program a copy of the legally required NPP, which you received and for which you signed. However, we can't cover all possible situations so please talk to our Privacy Officer about any questions or problems.

Medical information refers to all the information that is gathered and kept on file in the course of your psychotherapy. We will use the information about your health which we obtain from you or from others to provide you with treatment, to arrange payment for our services, and for some other business activities which are called health care operations. After you have read this NPP, we will ask you to sign a Consent Form to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an authorization form to allow us to do that. Of course we will keep your health information private, but there are some times when the laws require us to use or share it.

For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will share information only with a person or organization that is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For Workers Compensation and similar benefit programs.

Other less common situations like these are described in the full NPP document.

### **Your rights regarding your health information:**

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. Should we agree to honor your request, we do so unless it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you, such as your medical and billing records. You can even get a copy of these records, but we may charge you. Contact our Privacy Officer to arrange how to see your records or obtain a copy. (See below.)
4. If you believe the information in your records is incorrect or missing important information, you can ask us to amend your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us why you want to make the changes.
5. You have a right to a copy of this notice. If we change this NPP, we will post the new version in our waiting area and you can always get a copy of the NPP from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the care we provide to you in any way.

If you have any questions regarding this notice or the privacy policies of COBYS Family Services, please contact our Privacy Officer:

Abby L. Keiser, MS, Director of Family Life Services  
1417 Oregon Road, Leola, PA 17540  
Phone: 717-661-3548  
Email: [counselingadmin@cobys.org](mailto:counselingadmin@cobys.org)

The full version of NPP will be provided upon request. The effective date of this notice is March 23, 2017.





COBYS Family Services  
1417 Oregon Rd., Leola, PA 17540  
Phone: 717-661-3548  
Fax: 717-656-3056 · Web: [www.cobys.org](http://www.cobys.org)

## **Consent to Use and Disclose Your Health Information Under the Health Insurance Portability and Accountability Act of 1996**

This form is an agreement between you, \_\_\_\_\_, and COBYS Family Services. When we use the word “you” below, it will mean you or your child. Marital therapy clients both must sign an agreement. When we evaluate, diagnose, treat, or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We use this information to decide what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this consent form. If you do not sign this consent form, agreeing to what is in our Notice of Privacy Practices, we cannot offer psychotherapy/counseling to you. This is a provision of the Health Information Portability and Accountability Act of 1996, effective April 14, 2003.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our website, by calling us, or from our privacy officer. If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing.

Although we will try to respect your wishes, we are not required in every instance to agree to these limitations. However, if we do agree, we promise to comply with your wishes. After you have signed this consent, you have the right to revoke it by writing a letter telling us you no longer consent. We will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information.

\_\_\_\_\_  
Signature of client or parent/guardian of client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client or parent/guardian of client

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

Date on which copy given to the client or parent/guardian \_\_\_\_\_

*Privacy Officer: Abby L. Keiser M.S, Director of Family Life Services  
COBYS Family Services is dedicated to the highest degree of confidentiality under the law.*



COBYS Family Services  
1417 Oregon Rd., Leola, PA 17540  
Phone: 717-661-3548  
Fax: 717-656-3056 · Web: [www.cobys.org](http://www.cobys.org)

## **Client Information and Consent to Treatment**

COBYS Family Services provides therapy to help clients with individual, marital, or family problems. Counseling is voluntary and will be provided without discrimination on the basis of race, sex, religion, ethnicity, national origin, marital status, handicap, sexual orientation, or age. If you need adjunctive mental health services beyond outpatient treatment, we are happy to refer to other treatment providers.

### **Fee and Payment Service**

Psychotherapy fees are standard depending on the type and length of treatment session. Client fees are to be paid at each session by cash, check or credit card made payable to COBYS Family Services. Some of our therapists are on some insurance panels. For those situations we will submit your claims on your behalf. If we are out of network and you would like to use your insurance benefits, we will provide you the necessary documentation, but **you are responsible for determining if your health insurance covers the counseling services you are receiving**. If you have a change in insurance, you are responsible to report it immediately to prevent a lapse in services. You will be responsible for all fees if COBYS was not informed of insurance change. A sliding scale fee is available for those who do not have insurance. Your therapist will determine the fee during the first session.

In addition to therapeutic session fees, we charge for other professional services you may need including report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries. If you become involved in legal proceedings that require our participation, you will be expected to pay for our professional time even if we are called to testify by another party.

### **Appointments and Cancellations**

All appointments and the cancellations of appointments are made directly with the COBYS therapist or counseling secretary by calling 717-661-3548 between 8:30 a.m. and 4:30 p.m. **Your full fee will be charged for no-shows or cancellations made with less than 24 hours notice.**

### **Emergencies**

For life threatening emergencies, dial 911. COBYS does not provide crisis or emergency service. In the case of an emergency, please call your county crisis unit or go to your local Emergency Room. Lancaster Crisis Intervention Unit: **717-394-2631**. Lebanon Crisis Intervention Unit: **717-274-3363**.

### **Confidentiality**

While receiving service from this agency, you shall retain all rights of confidentiality, except where restricted by law. Any child or adolescent under the age of 18, unless legally emancipated or graduated from high school, will be treated only with the full knowledge and approval of that individual's parent, guardian, and/or primary caregiver.

All verbal and written material shared between you and your therapist will be kept strictly confidential, with these exceptions: A) Information for which you give informed written consent to release; B) Issues involving concern about your own or someone else's physical safety; C) Information regarding abuse of a minor or elder; D) Court orders; and E) Supervision, consultation, and/or professional training of your therapist. All professionals also are bound to the laws of confidentiality. Every effort is made to reveal only necessary information. COBYS Family Services is compliant with the Federal Health Insurance Portability and Accountability Act (HIPAA) regarding confidentiality.

If COBYS and its staff have reason to suspect that a child is or has been abused and/or neglected, we are required to report our suspicions to the appropriate authorities. We are required to make such reports even ***if we do not see the child in a professional capacity***. COBYS and its staff are mandated to report suspected child abuse if anyone aged 14 or older tells us that he or she committed child abuse, even if the victim is no longer in danger. We are also mandated to report suspected child abuse if anyone tells us that he or she knows of any child who is currently being abused.

### **Special Considerations Regarding Children**

At COBYS we work with children within the context of their family system. We ask that both parents consent to treatment regardless of parent separation or divorce, except in unusual circumstances which can be discussed with your therapist. We encourage all parents to be involved in treatment of your child. Our role as your child's therapist is limited to only providing treatment, and we are ethically bound to refrain from making recommendations concerning custody or visitation arrangements.

### **Notification of Referring Person**

We believe that most people function within a community. For this reason, if you have been referred to COBYS Family Services by a professional, such as a pastor, physician, therapist, social worker, etc., it may be helpful for us to collaborate with them. We will do so only with your written permission.

## Weapons Policy

Consistent with COBYS Employee Policy regarding weapons and firearms, no weapons are permitted on COBYS property including in vehicles on the parking lot or in your possession. Weapons include any object that would typically be considered a weapon and other objects if they are used in a weapon-like manner. Pocket knives used only for typical utility purposes and pepper spray intended for personal protection will not be considered weapons, if used and stored properly.

### **Release of Information to Insurance Company and Benefits Assignment for Claims**

By signing this form, you consent for COBYS to release information to and bill your health insurance company, and for your insurance company to make payments directly to COBYS.

### **Termination or Transfer of Service**

You may discontinue treatment at any time. We request that therapy be terminated in a final face-to-face termination session with your therapist, rather than by phone or mail.

## Concerns

COBYS encourages you to share concerns or suggestions about the quality of your treatment with your therapist. In case of a grievance that cannot be resolved between the therapist and the client/family, the client(s) may discuss the concern by phone, in writing, or in person with the Supervisor of Counseling Services. If this is unsatisfactory, you may contact the Executive Director, COBYS Family Services, 1417 Oregon Road, Leola, PA 17540

**I signify that I have received the above information. I agree to these policies and want to join the therapeutic relationship for treatment services.**

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Date \_\_\_\_\_

---

Parent/Guardian Signature	Date
---------------------------	------

Date \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_

Date \_\_\_\_\_

Counseling Location

## Application for Compassion Care Fund

The fee for psychotherapy services at COBYS is \$120 per session. You may be eligible for our **Compassionate Care Fund**, which is provided by private donations from individuals, churches, and others. If you feel this would be applicable, please complete income information below. If you need assistance, call the counseling program administrative assistant at 717-661-3548 or 1-800-452-6517.

\*Please bring verification of the income to first session (i.e., payroll stub, income tax form, etc.) or the full fee will be charged.

### Income Information

COMBINED GROSS INCOME OF HOUSEHOLD MEMBERS				
NAMES OF ALL ADULTS IN HOUSEHOLD	EARNINGS FROM EMPLOYMENT	NON-EMPLOYMENT INCOME	SOCIAL SECURITY PENSIONS, RETIREMENT, DISABILITY INCOME	TOTAL OF EACH LINE
	\$	\$	\$	\$
	\$	\$	\$	\$
	\$	\$	\$	\$
	\$	\$	\$	\$
COMBINED YEARLY	MONTHLY	INCOME (check which one used)		\$

*Client complete form to this line.*

### Fee Payment Agreement (to be completed with counselor):

\_\_\_\_\_ I (We) agree to pay the full cost of \$130 for the initial intake session.

\_\_\_\_\_ I (We) agree to pay the full cost of each session.

\$120 per 1 hour session or \$95 per 45 minutes session.

\_\_\_\_\_ I (We) want to participate in counseling; however, the cost is a financial hardship for myself/family.

I (We) agree to pay a fee based on my (our) income using the Compassionate Care Fund. I (We) certify that the household income information provided above is true and correct and that all income was reported. The income information is being given so a fee can be determined.

My (Our) fee is \$\_\_\_\_\_ per counseling session (45 min.). I (We) understand that \$\_\_\_\_\_ will be paid on my (our) behalf from the Compassionate Care Fund.

\_\_\_\_\_ A third party/church/insurance company will pay all or a portion of my (our) fee. Name and address of third party (church, family, agency, or insurance company) is

My (Our) part: \$\_\_\_\_\_

Third party: \$\_\_\_\_\_

\*I (We) understand that I (we) am ultimately responsible for my fee

I understand how the counseling fee has been determined and the terms of payment. Payment is expected at time of service.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_



COBYS Family Services  
1417 Oregon Rd., Leola, PA 17540  
Phone: 717-661-3548  
Fax: 717-656-3056      Web: [www.cobys.org](http://www.cobys.org)

### **Appointment Reminders Authorization Form**

COBYS now offers appointment reminders to our clients by email, text message, and/or automated phone calls. Appointment reminders are for your convenience only. Our cancellation policy and fees still apply.

#### **About Email Reminders**

Automated email reminders are sent between 60 and 20 hours in advance of the appointment.

#### **About Text Message (SMS) Reminders**

Automated text (SMS) reminders are sent between 24 and 2 hours in advance of the appointment, between 8AM and 9PM. Only mobile phones can receive text message reminders. To opt out of text appointment reminders, reply "STOP" to the message.

#### **About Phone Call Reminders**

Automated phone call reminders are sent between 24 and 2 hours in advance of the appointment, between 8AM and 9PM. Home or mobile phones can receive voice message reminders. If you do not answer, the automated service leaves a voicemail and repeats the following message twice: "This call is to remind you about your appointment <day> at <time> with COBYS Family Services. Please call our offices at 717-661-3548 if you have any questions or will not be able to attend. If you would like to disable appointment reminders by telephone, please talk to your clinician." These calls will come from a 215 area code.

Select one:      **No reminders**

#### **Email Only**

Use this email address: \_\_\_\_\_

#### **Text (SMS) Only**

Use this mobile number: \_\_\_\_\_

#### **Text (SMS) and Email**

Use this mobile number: \_\_\_\_\_

And use this email address: \_\_\_\_\_

#### **Text or Automated Phone Call, and Email**

Use this mobile or home number: \_\_\_\_\_

And use this email address: \_\_\_\_\_

#### **Text or Automated Call only**

Use this mobile or home number: \_\_\_\_\_

\_\_\_\_\_  
**Printed Name of Client**

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**Printed Name of Parent/Guardian of Client (if applicable)**

\_\_\_\_\_  
**Signature of Client or Parent/Guardian of Client**  
(may sign electronically)

\_\_\_\_\_  
**Date**



**COBYS Family Services**  
**1417 Oregon Road, Leola, PA 17540**  
**Phone: 717-661-3548**  
**Fax: 717-656-3056    Web: [www.cobys.org](http://www.cobys.org)**

## **INFORMED CONSENT FOR TELETHERAPY**

### **COBYS FAMILY SERVICES COUNSELING DEPARTMENT**

This Informed Consent for Teletherapy contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully, and let us know if you have any questions. When you sign this document, it will represent an agreement between us.

#### **Benefits and Risks of Teletherapy**

Teletherapy refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of Teletherapy is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of in these challenging times. Teletherapy, however, requires technical competence on both our parts to be helpful. Although there are benefits of Teletherapy, there are some differences between in-person psychotherapy and Teletherapy, as well as some risks. For example:

- Risks to confidentiality. Because Teletherapy sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On our end, therapists will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for teletherapy sessions where you will not be interrupted. It is also important for you to protect the privacy of your session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.
- Issues related to technology. There are many ways that technology issues might impact Teletherapy. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.
- Crisis management and intervention. Usually, a therapist will not engage in Teletherapy with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in Teletherapy, you and your therapist will develop an emergency response plan to address potential crisis situations that may arise during the course of our Teletherapy work.

- Efficacy. Most research shows that Teletherapy is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

### **Electronic Communications**

Your therapist and you will decide together which kind of Teletherapy service to use. You may have to have certain computer or cell phone systems to use Teletherapy services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in Teletherapy.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach your therapist by phone. Your therapist will try to return your call within 24 hours except on weekends and holidays. If you are unable to reach your therapist and feel that you cannot wait for them to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call.

### **Confidentiality**

We have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our Teletherapy. However, the nature of electronic communications technologies is such that we cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. We will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for Teletherapy sessions and having passwords to protect the device you use for Teletherapy).

The extent of confidentiality and the exceptions to confidentiality that we outlined in the original ***Client Information and Consent to Treatment*** still apply in Teletherapy. Please let us know if you have any questions about exceptions to confidentiality.

### **Emergencies and Technology**

Assessing and evaluating threats and other emergencies can be more difficult when conducting Teletherapy than in traditional in-person therapy. To address some of these difficulties, please refer to your Wellness Plan. We ask you to identify an emergency contact person who is near your location and who your therapist will contact in the event of a crisis or emergency to assist in addressing the situation.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call your therapist back; instead, call 911 or Crisis Intervention at 717.394.2631 or go to your nearest emergency room. Call your therapist back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and your therapist will contact you within two (2) minutes via the VSee platform on which we agreed to conduct therapy. If you are unable to connect through VSee, your therapist will call you individually on the number you previously provided.

If there is a technological failure and we are unable to resume the connection, we will only charge you for the actual session time.

### **Fees**

The same fee rates will apply for Teletherapy as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in Teletherapy sessions in order to determine whether these sessions will be covered.

### **Records**

The Teletherapy sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

### **Informed Consent**

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist

\_\_\_\_\_  
Date





COBYS Family Services  
1417 Oregon Road, Leola, PA 17540  
Phone: 717-661-3548 · Fax: 717-656-3056  
www.cobys.org

## Authorization Agreement for Credit Card Payment for Counseling Services

For payment to COBYS Family Services via your credit card account, simply complete and sign the form below. Your payment will appear on your statement.

Name Printed on Credit Card \_\_\_\_\_

Card Account Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

E-mail Address \_\_\_\_\_ Telephone \_\_\_\_\_

---

### USE FOR RECURRING CHARGES ONLY

---

I understand that my credit card account will be charged in the amount of \$ \_\_\_\_\_ immediately after each session.

I also understand that my credit card account will be automatically charged for any unpaid balances, including session fees, co-payments, deductibles, coinsurance, and failed appointment and late cancellation charges.

Please tell us how long you want us to automatically bill your credit card:

☐ This authorization is valid until I provide you with written cancellation.

☐ This authorization is valid until \_\_\_\_\_

### USE FOR ONE TIME CHARGES

---

☐ I understand that my credit card account will be charged in the amount of \$ \_\_\_\_\_ for a one time only charge.

☐ Visa    ☐ MasterCard    ☐ Discover    ☐ American Express

Account number: \_\_\_\_\_ CVV Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

I hereby authorize COBYS Family Services to charge my credit card as designated above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

*You may cancel this automatic billing authorization at any time by contacting us in writing at COBYS Family Services, 1417 Oregon Road, Leola, PA 17540. For questions, contact Counseling Administrative Assistant Sheila Thum at 717-661-3548 or [sthum@cobys.org](mailto:sthum@cobys.org)*



COBYS Family Services  
1417 Oregon Rd., Leola, PA 17540  
Phone: 717-661-3548  
Fax: 717-656-3056 · Web: [www.cobys.org](http://www.cobys.org)

## PerformCare Provider Choice

The purpose of this form is to inform you that, as a PerformCare member, you have choices regarding your healthcare provider.

You can choose your provider.

For each level of care, there are providers available for you to choose from.

You can choose a provider that is close to you.

You can choose a provider that offers the care you need.

You can choose a provider who can relate to you, speak your language, or provide needed interpretation for you.

If you are not happy with a provider, you can choose a different provider.

PerformCare members can request appointments at times that are convenient for them.

Providers also will talk with you about choices you have.

Call PerformCare at 1-888-722-8646 for provider information, or you can access a provider directory at [www.performcare.org](http://www.performcare.org).

### **Appointments and Cancellation Policy**

All appointments and the cancellations of appointments are made directly with the COBYS therapist or counseling Administrative Assistant by calling 717-661-3548 between 8:30 a.m. and 4:30 p.m. We honor your appointment time. A 24-hour notice to cancel an appointment is expected. You will be discharged from treatment after two no-shows or cancellations made with less than 24 hours notice.

I have read and/or have had the contents of this form explained to me and understand my rights with regard to provider choice.

Signature\_\_\_\_\_

(Adult over 18 years of age)

Date\_\_\_\_\_

Signature\_\_\_\_\_

(Adult over 18 years of age)

Date\_\_\_\_\_

Signature\_\_\_\_\_

(Minor over 14 years of age)

Date\_\_\_\_\_

