Saadia Z. Yunus, LMFT
Licensed Marriage and Family Therapist
2061 Deer Park Ave. Ste. 206, Deer Park, NY 11729
Phone : 631.213.1236 Email: info@saadiazyunus.com

Client Information

Today's Date: _____

First Name: _____ Last Name: _____

Home Address: _____

DOB: _____ Email: _____

Home Phone #: _____ Can I leave messages? Y N

Cell: _____ Can I leave messages? Y N

Preferred method of communication: Phone / Text / Email

Profession: _____ Ethnicity: _____

Spiritual Orientation: _____ Any previous therapy? Y N

Partner Name: _____ Partner Cell Phone #: _____

DOB: _____ Partner email: _____

Profession: _____ Ethnicity: _____

Spiritual Orientation: _____ Any previous therapy? Y N

Emergency Contact: _____ Phone number: _____

Primary care physician name and phone #: _____

List of medications: _____

Reason for your visit: _____

_____

Children/Siblings: Please list their names, ages, and genders

_____

_____

_____

How did you hear about my services?

_____

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INFORMED CONSENT

Therapist Background and Professional Orientation

Welcome! I am happy to have you as a client and will do everything within my professional capacity to make your expenditure of time, energy, and money productive for you. My name is Saadia Z. Yunus and I am a licensed marriage and family therapist with a Masters degree in Marriage and Family Therapy from Hofstra University. I am a clinical member of the American Association of Marriage and Family Therapy trained to provide individual, couple, group and family therapy.

The Therapeutic process

Therapy is a process. We will work together to develop goals and we will revisit these goals periodically. Therapy is a joint effort of which the results cannot be guaranteed. Progress depends on many factors including your motivation, effort, and other life circumstances. Therapy may be difficult and uncomfortable at times. Feelings of unhappiness, anger, guilt or frustration are a natural part of the therapy process and often provide the basis for change. Keep in mind, sometimes positive decisions for you may be viewed negatively by those around you. And when participating in couple or family therapy, sometimes a positive change for the couple or family can mean discomfort for an individual in that system. The majority of the time, the termination of treatment is a mutual decision between the client and therapist. You are free to terminate treatment at any time. If at any time I feel you would be better suited with another professional or service, I will suggest a referral.

It is important to note that I do not give custody recommendations and do not get involved in the legal aspects of divorce and custody.

Dual Relationships & Social Media

I will never acknowledge working therapeutically with anyone without his/her written permission. In some instances, even with permission, I will preserve the integrity of our working relationship. For this reason, I will not accept any invitations via social networking sites. If we should see each other in person in a setting outside of therapy, I will not approach you first so as to protect your privacy.

Therapy Session and after- hours Contact information

Therapy sessions are 45 minutes long and I am available to you during your scheduled appointment. I do understand the importance of questions and concerns outside of sessions. You can leave a voicemail, text message, or send a brief email and I will return your call/message within 24 hours. On occasion or on weekends, I may be unable to return your call until the next business day. If you cannot reach me about an urgent matter or have an emergency, call 911 or go to the nearest emergency room. You will be notified in case of office vacation time and as to the date on which I will return and to respond to your messages.

Fees and Cancellations

In order to provide you with the highest quality of care, details of financial arrangements are as follows: Fees are $200.00 paid via Ivy Pay, a secure app for therapists. You will be notified through text to enter your credit or debit card on file. Prior to each scheduled session, your card will be charged automatically and you will be notified of the charge. Failure to meet your financial responsibility may result in the termination of treatment. If an outstanding balance exists and good faith payment arrangements are not made within 60 days, your name and address, dates of professional services rendered, and the amount of unpaid balance may be submitted to a collection agency.

If you are unable to make your appointment, please let me know as soon as possible. **There is a 24- hour cancellation policy**. A service charge of **half** of your session fee will be charged if an appointment is missed or not cancelled within twenty- four (24) hours of the scheduled time. In case of credit card dispute, the office will share the signed consent with the credit card agency. Please note, after two missed sessions, your appointment time may no longer be available.

Confidentiality

Information disclosed by you during the course of therapy is generally confidential. However, there are exceptions to confidentiality, including, but not limited to reporting child, elder, or dependent adult abuse, expressed threats of violence towards an identifiable victim (including harm to self), and where you tender your mental or emotional state in a legal proceeding. You can always give us your written consent to allow us to exchange information with others. This may include, but is not limited to previous therapists, medical doctors, psychiatrists, and teachers. For clients under the age of twelve, therapists are obligated to keep parents or guardians informed of progress of therapy. This means if information is disclosed during 1:1 interview that is relevant to the progress of family work, we will not keep this information secret. We will work with you on the most comfortable way to disclose the information to the rest of the client family. Please feel free to ask questions at any point during treatment to clarify limits of confidentiality.

Electronic Communication

It is very important to be aware that computers, email and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. Additionally, our emails and data on computers are not encrypted. They are equipped with a firewall, virus protection and passwords. Please notify your therapist if you decide to avoid or limit, in any way, the use of emails or texts. If you communicate confidential or private information via email, we will assume that you have made an informed decision, will view it as your arrangement to take the risk that such communication may be intercepted, and will honor your desire to communicate via email. Please do not use emails for emergencies or for therapeutic content. Emails and texts should be used for scheduling and forms only. Due to computer or network issues, emails may not be deliverable, and may not be checked daily.

I have read and agree to the above information, including information provided in all sections of this document (Therapist Background and Professional Orientation, Therapeutic process, Counseling Session and after- hours Contact information, Fees and Cancellations, Confidentiality, and Electronic Communication) and hereby give my consent to treatment. Additionally, I authorize Saadia Z. Yunus to contact me by email, phone, and electronic means at the mailing address, phone numbers, and email addresses provided on the client information form. Any exceptions to this authorization to contact are noted below:

_____

_____

_____

Name:---------- **Date:**----------

Signature:----------

Name:---------- **Date:**----------

Signature:----------

Name:---------- **Date:**----------

Signature:----------

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INFORMED CONSENT FOR TELETHERAPY

What is Teletherapy?

Telecommunication: Teletherapy (e-therapy) refers to providing therapy services remotely via telecommunications technologies, such as video conferencing or telephone to treat the needs of a patient. Teletherapy offers improved access to care for clients and more flexibility with scheduling. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person.

Limitations of Teletherapy

Teletherapy, however, requires technical competence on both therapist's and patient's 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. Risks include but aren't limited to:

- **Risks to Confidentiality.** As teletherapy sessions take place outside of the therapist's private office, there is potential for other individuals to overhear sessions if you as the patient are not in a private place during the session. Thus, on my end as the therapist, I will take reasonable steps to ensure your privacy. I 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. It is also important for you to make sure you find a private place for our session where you will not be interrupted. In addition, it is important for you to 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).
- **Issues Related to Technology.** There are many ways that technological issues might impact teletherapy. For example, technology may stop working during a session. Should a video or telephone session experience a disruption/technological failure, the patient is to text the therapist unless other arrangements between patient and therapist are agreed upon.

Teletherapy Platforms

You are solely responsible for any costs relating to you obtaining necessary equipment, accessories, software, internet access needed to partake in teletherapy. It is also your responsibility to arrange a location with sufficient lighting and privacy that is free from distractions or intrusions during the therapy sessions. For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. In order to provide efficient services to clients and ensure client confidentiality, I use Doxy.me for telehealth services and can be accessed at Doxy.me/saadiazyunus. Teletherapy sessions are available by appointment only. Should I determine that teletherapy is no longer appropriate, the client will be referred out to an in-person therapist near them.

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.

This agreement is intended as a supplement to the general informed consent that we agreed upon and does not amend any of the terms of that agreement. Your signature below indicates agreement with its terms and conditions.

Name:---------- **Date:----------**

Signature:----------

Name:---------- **Date:----------**

Signature:----------

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THERAPY CONTRACT

While I expect benefits from this therapy, I fully understand and accept that because of factors beyond our control, such benefits and desired outcomes cannot be guaranteed

I understand that the therapist is not providing emergency service and I have been informed of where and whom to call in an emergency or during evening or weekend hours

I have been informed and understand the limits of confidentiality that by law, the therapist must report to appropriate authorities any suspected child abuse or serious threats to harm myself or another person

I am not aware of any reason why I/ we/ she/ he should not process with therapy and I/ we/ she/ he agree to participate fully and voluntarily

I have had the opportunity to discuss all aspects of therapy fully, have had questions answered, and understand the treatment planned. Therefore, I agree to comply with therapy and authorize that the therapist named below to administer treatment to me and/or child (ren).

Children under 14 need not sign

Client's Name: ----------

Client's Signature:---------- Date:----------

Client's Name: ----------

Client's Signature:---------- Date:----------

Client's Name: ----------

Client's Signature:---------- Date:----------

Therapist's Name: Saadia Z. Yunus, LMFT

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Health Insurance Portability & Accountability Act (HIPAA)
Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment

reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.

5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the State of New York. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the State of New York. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment*** **–** I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- ***For Operations*** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Patient's Rights:

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.

- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- ***Right to a Copy of This Notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of New York Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Client Signature Date

_____

Client Printed Name

_____ _____

Client Signature Date

_____

Client Printed Name

_____ _____

Client Signature Date

_____

Client Printed Name

S. Y

_____

Therapist Signature