

Iris Avishai Cohen, LCSW-R
Clinical Psychotherapist
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Psychotherapist-Client Service Agreement

Welcome to my psychotherapy practice. This document contains important information about my professional services and business policies.

Appointments:

Each psychotherapy session is scheduled at a weekly agreed-upon time. Please note that each appointment time is scheduled for you and only you. If you need to cancel or reschedule an appointment, 48-hours notice is requested or you will be responsible for the full payment of the session. If I am able to fill your missed appointment or reschedule you for a different time during the week of your appointment, you will not be charged.

Confidentiality:

The confidentiality of all communication between client and therapist is generally protected by state and federal laws. I will keep the content of our session in the strictest of confidence and will only disclose information with your signed consent.

The Health and Insurance Portability Act {HIPPA} provides protection and patents rights with regard to the use and disclosure of your protected health information for the purpose of treatment, payment and health care operations. If HIPPA laws apply to our treatment I am happy to provide you with a copy if requested.

There are certain exceptions to confidentiality in which I am required by law to reveal information obtained during therapy to other persons or agencies without your consent. These include but are not limited to learning about any information that could result in danger or harm to yourself or others. In addition if you are involved in litigation or became so involved the court may request a report, a mental health evaluation or your medical records.

Availability:

You can reach me by email or phone. Please let me know the urgency of your call and the best times to reach you. I will respond as soon as possible.

Please note that confidentiality is not guaranteed for email communications.

If you are calling with an emergency it remains your responsibility to take care of yourself until we can find a time to speak. In these cases, please contact your family physician, psychiatrist, family member or friend. In the case of an emergency where myself or anyone else cannot be reached please call 911 or go to the nearest emergency room.

Telemedicine Informed Consent form:

I _____ (patient) hereby consent to engaging in telemedicine with Iris Avishai Cohen, LCSW (psychotherapist) as part of my psychotherapy. I understand that “telemedicine” includes the practice of health care delivery, diagnosis, consultation, treatment using interactive audio-video communications. I also understand that, with my signed consent, telemedicine may involve the electronic communication of my medical/mental healthcare information to other health care practitioners. The rights stated supplement those rights I have generally as a patient of the psychotherapist. I understand that I have the following rights with respect to telemedicine:

I have the right to withhold or withdraw consent to telemedicine treatment at any time. The laws that protect the confidentiality of my medical/healthcare information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are mandatory exceptions to confidentiality, including reporting child abuse and the imminent risk of danger to self or others. If I put my mental state at issue in certain legal proceedings, then the psychotherapist may be compelled to release otherwise confidential information about my evaluation and treatment.

I understand that there are risks and consequences from telemedicine, including, but not limited to the possibility, despite reasonable efforts on the part of my psychotherapist, that the transmission of my medical information could be interrupted or distorted by technical failures or unauthorized persons, and that the electronic communication of my medical information could be accessed by unauthorized persons. Platforms like Doxy and Zoom are considered HIPPA compliant but do not guarantee unauthorized failures from intercepting medical information.

I understand that telemedicine services and care may not be as complete or effective as face-to-face services. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse. I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured. I also understand that if my psychotherapist believes that I would be better served by in-person psychotherapeutic services or a different level of care that they then have the option of referring me to a treatment provider

who can provide such services in my area. I understand that I do not have to accept those referrals.

As with all medical records, I understand that I have a right to access my medical information and copies of medical records of telemedicine treatment in accordance with New York State law. I have read and understand the information provided above. I have discussed it with the psychotherapist, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment.

Patient Signature

Date

Iris Avishai Cohen, Psychotherapist Signature

Date