Carol Nickerson, LICSW

New Patient Information

Patient Information

Name:_____

Mailing Address: _____City_____ State ____ Zip _____

Telephone _____ Other phone # _____

Sex-M or F Birth date: _____ Marital Status – M S D W

Primary Care provider: _____Referred by: _____

Medications: _____ Allergies _____

In case of emergency:

Name: _____ Phone # _____ Relationship: _____

Insurance information -#1

Insurance name: _____

Address: _____ City_____ State _____

Telephone #: _____

Subscriber name:_____. Subscriber address:_____

Relationship to patient: _____ Policy copay _____

Subscriber #ID _____ Group # _____ Policy # _____

Who will pay copayments? _____

Employer/ Name of business: _____

Insurance #2 (if appropriate)

Insurance name: _____ Telephone # _____

Address: _____ City_____ State _____

Subscriber name:_____ Subscriber address:_____

Relationship to patient: _____ Policy copay _____

Subscriber #ID _____ Group # _____ Policy # _____

Who will pay co-payments? _____

Employer/ Name of business: _____

Standard patient/Authorized person's signature waiver/Please read and sign both sections

Release of information:

I (patient, parent, guardian) authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed: _____ Date: _____

Patient/authorized person

Assignment of Benefits

I authorize payment of medical benefits to Carol Nickerson, LICSW

Signed: _____ Date: _____

Patient/authorized person

Diagnosis _____ **Procedure** _____ **Fee** _____

Client handout

You, the client, has the right to:

- Receive respectful treatment that will be helpful to you.
- Receive a particular type of treatment or end treatment without obligation or harassment.
- A safe environment, free from sexual, physical, and emotional abuse.
- Report unethical and illegal behavior by a therapist.
- Ask questions about your therapy.
- Request and receive full information about a therapist's professional capabilities, including licensor, education, training, experience, professional association membership, specialization, and limitations.
- Have written information about fees, methods of payment, insurance reimbursement, number of sessions, substitutions (in case of vacation and emergencies), and cancellation policies before beginning therapy.
- Refuse electronic recording, but you may request it if you wish.
- Refuse to answer any questions or disclose any information you choose not to reveal.
- Know limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others.
- Know if there are supervisors, consultants, students, or others with whom your therapist will discuss your case.
- Request, and in most cases receive, a summary of your file, including the diagnosis, your progress, and type of treatment.
- Request the transfer of a copy of your file to any therapist or agency you choose.
- Receive a second opinion any time about your therapy or therapist's methods
- Request that the therapist inform you of your progress.

Limits of Confidentiality/informed consent

Information discussed in sessions is held confidential and will not be shared **without written permission** except under the following conditions:

- The client threatens to harm him/herself and/or threatens suicide, or if he/she is evaluated as high risk for suicide.
- The client threatens to harm another person(s), including murder, assault, or other physical harm.
- The client is a minor (under 18) and reports suspected child abuse, including but not limited to physical beatings, and sexual abuse, or other high risk, unsafe behavior.
- The client reports abuse of elderly.
- The clinician is ordered to by a judge.
- I use a billing service which processes information for insurance companies in order to process your claims.
- In the event of unpaid accounts, information about your account can be sent to a collection agency.
- I do not have any control over the confidentiality of any information once it is disclosed to your insurance company and I cannot tell you whether employers have access to information about you or if such information is distributed by the insurer to national information centers.

Consultation with other professionals

I have trusted colleagues, mentors who I consult with in order to provide optimal services. Details are withheld to maintain your confidentiality; anonymity is maintained.

Fee and Cancellation Policy

My services are most often covered by health insurance. Different health plans have different policies and procedures. You are responsible to know what your policy's procedures are. Payment (full fee or co-pay) is required at the time of each session, unless other arrangements are made. This policy helps keep costs as low as possible. Your appointment time is set aside exclusively for you; in the event you do not keep your appointment, you may be billed for the amount of your session (no show/ inadequate notice fee: $100). If, however, you give adequate notice of a cancellation, 24 (twenty-four) hours, there is no charge. Emergencies and weather conditions are also exceptions.

Appointments and Telephone calls

- Routine appointments are 50 minutes long. On occasion, the time may be slightly more. I do my best to stay on time, and once in a while I need to spend a few extra minutes with a client due to certain circumstances. I am able to return most phone calls within one to two business days.
- I am available to provide sessions on the telephone, however, to date, insurance companies only cover face to face sessions. If you leave me a message and don't hear back from me within the above time frame indicated, please leave another message, sometimes technology has disruptions, cell phones may have gaps in reception, etc. When I take time away from the office I will have another clinician covering my practice; I provide that information on my outgoing message at the time I'll be away.

Treatment goals/medical necessity/insurance

People come for services for a variety of different reasons. Initial distress and accompanying symptoms usually qualify as "medically necessary", and is, therefore, reimbursable by insurance. When people begin to feel better and symptoms improve, it doesn't mean that therapy should be considered completed. Sometimes more sessions are needed for lasting progress, or behavioral changes. After the initial reduction in symptoms, however, insurance companies may view continued sessions as useful, however, no longer "medically necessary" and therefore not reimbursable. Approval is determined by the insurers' guidelines and the criteria for "medical necessity". Many people elect to continue beyond the limits the insurance and some choose not to use insurance at all.

This page is yours to keep.

Carol J. S. Nickerson, L.I.C.S.W.
For client/patient

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at __P O Box 563 North Chatham, MA 02650_____:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at _____ or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257.

We will not retaliate against you for filing a complaint.

The effective date of this Notice is September 2013.

Carol J. S. Nickerson, LICSW
(508) 432-5640

Client Copy

Cancellations/missed appointments:
Your appointment time is set aside exclusively for you; in the event you do not keep your appointment, you may be billed for the amount of your session. Your insurance does not cover you in such cases.

Adequate notice/emergencies:
If you give adequate notice of a cancellation, 24 (twenty-four) hours, there is no charge. Weather conditions, illness and emergencies are taken into consideration.

Consent to treat:
I give my consent to Carol J. S. Nickerson, MSW, LICSW to provide treatment and therapy necessary or advisable for myself and/or my child's overall well-being. I understand that I may stop treatment at any time and that Carol J. S. Nickerson has the same right. I understand that it is advisable to discuss reasons before stopping (See Ending Tx below for more on this).

Service Fees and payment arrangements/rates as of February 1, 2003

Initial visit	$150.00
Individual, 45-50 minutes.	$125.00
Couples/family, 45-50 min.	$140.00
No show/inadequate notice*	$100.00

**Please provide 24 hour notice of cancellation or you will be charged directly. Clients are responsible for missed appointment fees. Insurance cannot be billed for non-covered services and missed appointment fees.*

Ending Treatment/End of Treatment/Termination
Ending treatment is best when done in a planned, mutually agreed upon way. Stopping treatment without such an arrangement can undermine or "undo" progress that you've made in your sessions. I understand that I can return for sessions any time in the future and if Carol's schedule is full, or I cannot come when Carol has openings, that she will help me with a referral to a provider who takes my insurance.

Limits of confidentiality

- Information discussed in sessions is held confidential and will not be shared **without written permission** except under the following conditions:
- The client threatens to harm him/herself and/or threatens suicide, or if he/she is evaluated as high risk for suicide.
- The client threatens to harm another person(s), including murder, assault, or other physical harm.
- The client is a minor (under 18) and reports suspected child abuse, including but not limited to physical beatings, and sexual abuse, or other high risk, unsafe behavior.
- The client reports abuse of elderly.
- The clinician is ordered to by a judge.
- I use a billing service which processes information for insurance companies in order to process your claims.
- In the event of unpaid accounts, information about your account can be sent to a collection agency.
- I do not have any control over the confidentiality of any information once it is disclosed to your insurance company and I cannot tell you whether employers have access to information about you or if such information is distributed by the insurer to national information centers.

Payment:
___ 1. I will pay for each session by check or cash. (At my request this office will provide me with the appropriate information and receipts for me to obtain reimbursement for my health insurance carrier.)
___ 2. **I will pay the co-payment and/or deductible** for each session as performed and ask that you bill by health insurance company for the balance.
___ 3. **No co-pay**; I request that you bill my insurance directly for services.
(I understand that I am liable for all costs of treatment and missed appointments, and I will compensate the therapist for any unpaid balances that my health insurance will not cover. I understand that if I am a member of an HMO/PPO, I understand that it is my responsibility to track how many sessions I have used, so if a preauthorization is needed, I can alert this office accordingly. I am responsible for payments of any sessions not paid by my HMO/PPO due to the lack of referrals and or authorizations.)

Billing service: I use CMS Inc. Billing service in Lakeville, MA; they provide attaining authorizations, and claim submission/trouble shooting. They receive only information that is pertinent to billing.

Confidentiality and rights: I have received and understand my rights and confidentiality limitations.

Receipt of Privacy Act information: I have received a copy of the above policies and a copy of the privacy act information.

I understand and agree to the above policies.

Carol J. S. Nickerson, LICSW
(508) 432-5640

Cancellations/missed appointments:
Your appointment time is set aside exclusively for you; in the event you do not keep your appointment, you may be billed for the full amount of your session. Your insurance does not cover you in such cases.

Adequate notice/emergencies:
If you give adequate notice of a cancellation, 24 (twenty-four) hours, there is no charge. Weather conditions, illness and emergencies are taken into consideration.

Consent to treat:
I give my consent to Carol J. S. Nickerson, MSW, LICSW to provide treatment and therapy necessary or advisable for myself and/or my child's overall well-being. I understand that I may stop treatment at any time and that Carol J. S. Nickerson has the same right. I understand that it is advisable to discuss reasons before stopping (See Ending Tx below for more on this).

Service Fees and payment arrangements/rates as of January 2019.

Initial visit	$150.00
Individual, 45-50 minutes	$125.00
Couples/family, 45-50 min.	$140.00
No show/inadequate notice*	$100.00

**Please provide 24 hour notice of cancellation or you will be charged directly. Clients are responsible for missed appointment fees. Insurance can not be billed for non-covered services and missed appointment fees.*

Ending Treatment/End of Treatment/Termination
Ending treatment is best when done in a planned, mutually agreed upon way. Stopping treatment without such an arrangement can undermine or "undo" progress that you've made in your sessions. I understand that I can return for sessions any time in the future and if Carol's schedule is full, or I cannot come when Carol has openings, that she will help me with a referral to a provider who takes my insurance.

Limits of confidentiality

- Information discussed in sessions is held confidential and will not be shared **without written permission** except under the following conditions:
- The client threatens to harm him/herself and/or threatens suicide, or if he/she is evaluated as high risk for suicide.
- The client threatens to harm another person(s), including murder, assault, or other physical harm.
- The client is a minor (under 18) and reports suspected child abuse, including but not limited to physical beatings, and sexual abuse, or other high risk, unsafe behavior.
- The client reports abuse of elderly.
- The clinician is ordered to by a judge.
- I use a billing service which processes information for insurance companies in order to process your claims.
- In the event of unpaid accounts, information about your account can be sent to a collection agency.
- I do not have any control over the confidentiality of any information once it is disclosed to your insurance company and I cannot tell you whether employers have access to information about you or if such information is distributed by the insurer to national information centers.

Payment:

___ 1. I will pay for each session by check or cash. (At my request this office will provide me with the appropriate information and receipts for me to obtain reimbursement for my health insurance carrier.)

___ 2. **I will pay the co-payment and/or deductible** for each session as performed and ask that you bill by health insurance Company for the balance.

___ 3. **No co-pay**; I request that you bill my insurance directly for services.

(I understand that I am liable for all costs of treatment and missed appointments, and I will compensate the therapist for any unpaid balances that my health insurance will not cover. I understand that if I am a member of an HMO/PPO, I understand that it is my responsibility to track how many sessions I have used, so if a preauthorization is needed, I can alert this office accordingly. I am responsible for payments of any sessions not paid by my HMO/PPO due to the lack of referrals and or authorizations.)

Billing service: I use CMS Inc. Billing service in Lakeville, MA; they provide attaining authorizations, and claim submission/trouble shooting. They receive only information that is pertinent to billing.

Confidentiality and rights: I have received and understand my rights and confidentiality limitations.

Receipt of Privacy Act information: I have received a copy of the above policies and a copy of the privacy act information.

I understand and agree to the above policies.

_____ _____
Signature of client/Guardian Date

_____ _____
Carol J. S. Nickerson, L.I.C.S.W. Date

Diagnostic Evaluation: _____. Date of birth: _____

Allergies:

Intimate relationships:

Medical/Health:

Substance abuse hx:

School/work status:

Friends/supports

Family:

Ethnic/cultural background and/or religion (if approp. For content)

Past losses and or traumas, including from childhood

Most recent physical: _____

Current medications: _____ Prescribed by: _____

Authorization

Contact by Telephone/Verbally in Event of Breach of PHI

I, _____, authorize Carol J. S. Nickerson, LICSW, to provide notice
Your name
to me by telephone or verbally in the event of a breach of my protected health information (PHI) by Carol J.S. Nickerson, LICSW. Such conversation shall be documented by Carol J. S. Nickerson, LICSW.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Carol Nickerson, LICSW.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

Carol J. S. Nickerson, L.I.C.S.W. Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Patient/Client Name:_____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Carol Nickerson's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Carol Nickerson, LICSW.

_____

Signature of Patient/Client Date

_____

Signature or Parent, Guardian or Personal Representative Date

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ Patient/Client Refuses to Acknowledge Receipt:

_____

Signature of Staff Member Date

Medical history form

Name:_____. **D.O.B: _____**

Allergies:

Current medications, including dosage:

Current health conditions:

Past health conditions (include childhood health) and dates:

Past injuries, surgeries (include childhood injuries, hospitalizations) and dates:

_____ _____

Signature Date

Carol J. S. Nickerson, LICSW
508-432-5640, South Harwich MA

Telemental Health Informed Consent

I _____, (client name) hereby consent to participate in telemental health with **Carol J. S. Nickerson, LICSW** as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2) I understand that there are risk and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call or text me at 508-237-1574 to discuss since we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____ and my emergency contact person's name, address, phone: _____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____. _____

Signature of client/parent/legal guardian Date

_____ _____

Signature of therapist Date

Consent for in-person Social Work Services for Covid-19

I, _____, consent to participate in in-person psychotherapy sessions with **Carol Nickerson, LICSW** at their place of business.

1. I understand the following with respect to in person sessions during the COVID-19 pandemic:

- I understand that COVID-19 is contagious and spreads primarily by person-to-person contact.
- I understand that my therapist has adopted a reasonable preventative measures intended to reduce the spread of COVID-19, but there is still a possibility of transmission as a result of attending in person therapy.
- I understand that federal and state laws typically authorize public health departments to collect patient information to prevent or control disease and for related public health needs.
- I understand that my therapist may be required to report COVID-19 related patient information to public health departments, HHS, or the CDC, e.g., for contact tracing or other data collection needs. If reporting is required, only the minimum necessary information will be disclosed.

2. I agree to following with respect to in person sessions during the COVID-19 pandemic:

- I will comply with safety precautions to limit the spread of COVID-19, as directed by my therapist.
- I will notify my therapist as soon as possible before my appointment if I have symptoms of COVID-19 or anyone in my household has been diagnosed with COVID-19. If this happens, I will cancel my appointment or arrange a remote session, unless my therapist direct me to come in.

I knowingly and willingly consent to have in person sessions during the COVID-19 pandemic, and I acknowledge the health risk of COVID-19 during this pandemic. I have read the information provided above and discussed it with my therapist, and all of my questions have been answered to my satisfaction.

_____. _____
Signature of client/parent/legal guardian. Date

_____. _____
Carol J S Nickerson, LICSW Date