

## **LIFE CHOICES ONLINE**

### **PATIENT RESPONSIBILITIES**

- 1). Payment is expected to be made through PayPal at least fifteen minutes prior to the start of the session in order to allow time for a receipt to be mailed to LCO.
- 2). Prior to beginning sessions, Contact Information, Consent to Treatment, The Brief Evaluation Questionnaire, Patient Responsibilities, Authorization, and Patient Rights forms must be read signed, and received by LCO. They may be faxed to LCO or emailed as an attachment.
- 4). Sessions are approximately 45-50 minutes. Please schedule a time when you are guaranteed privacy for this call. You will be called at your scheduled time and at the number you have provided for sessions.
- 5). You must provide a statement that you are currently residing in the state of Pennsylvania and that you are 18 years of age or older.
- 6). If you have an emergency or are unable to keep your appointment please give 24 hr. notice. The policy is that you will be charged for a full session if the appointment is missed without notice. Cases of emergency will be reviewed on an individual basis.
- 7). A written request must be received if you are requesting communication by email, electronically, or paper copy. This will be your permission to respond to such a request.
- 8). You are responsible to provide, to the best of your knowledge, complete and accurate information about current issues, complaints, medical history, psychiatric history, substance abuse history, and any history of self harm or suicide attempt/suicidal ideation. Please include medications for both medical conditions and behavioral health issues. Note, prescriptions are not offered through LCO.

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9). Changes in medications, your overall condition, must be reported. Any questions you have about treatment or what is expected of you should be shared. If you have an emergency you are expected to call 911 immediately and inform LCO as soon as possible of your status.

10). At times, reading or written assignments may be given when appropriate. They are considered supplemental to telephonic therapy and should be completed.

11). If you journal online, send communications by email, please attempt for your privacy to locate a secure email provider.

NOTE: Please take the time to read and make a copy of this document.

**Signature:** \_\_\_\_\_

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

**Statement of Residency: I, \_\_\_\_\_, do hereby confirm that I am a resident of the state of Pennsylvania and 18 yrs of age or older at the time which I have consented for treatment by Life Choices Online. In addition, I will update my therapist immediately if my state of residence should change.**

**Signature:** \_\_\_\_\_

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

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