

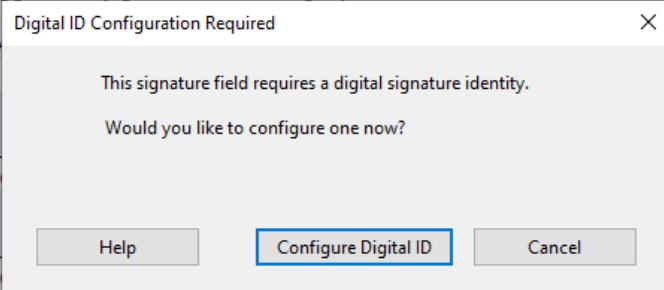
Instructions for Electronically Signing a PDF Document

- Once the document is opened in Adobe, carefully review the contents. If you are in agreement with the contents, locate the areas highlighted in blue to initial and sign your name.
- To initial, simply type your initials within the appropriate boxes. Once you are ready to sign the document, click on the highlighted area above the signature line to electronically sign the form.
- When you click on the signature line, you will be prompted to "Configure a Digital ID".

treatment. I am aware UCF is an equal opportunity provider and employer.

My signature below indicates that I understand and accept the terms and conditions of this document.

Patient Signature Date
Witness Signature Date



- Select "Create a New Digital ID" and select your desired save option.

Create a self-signed Digital ID

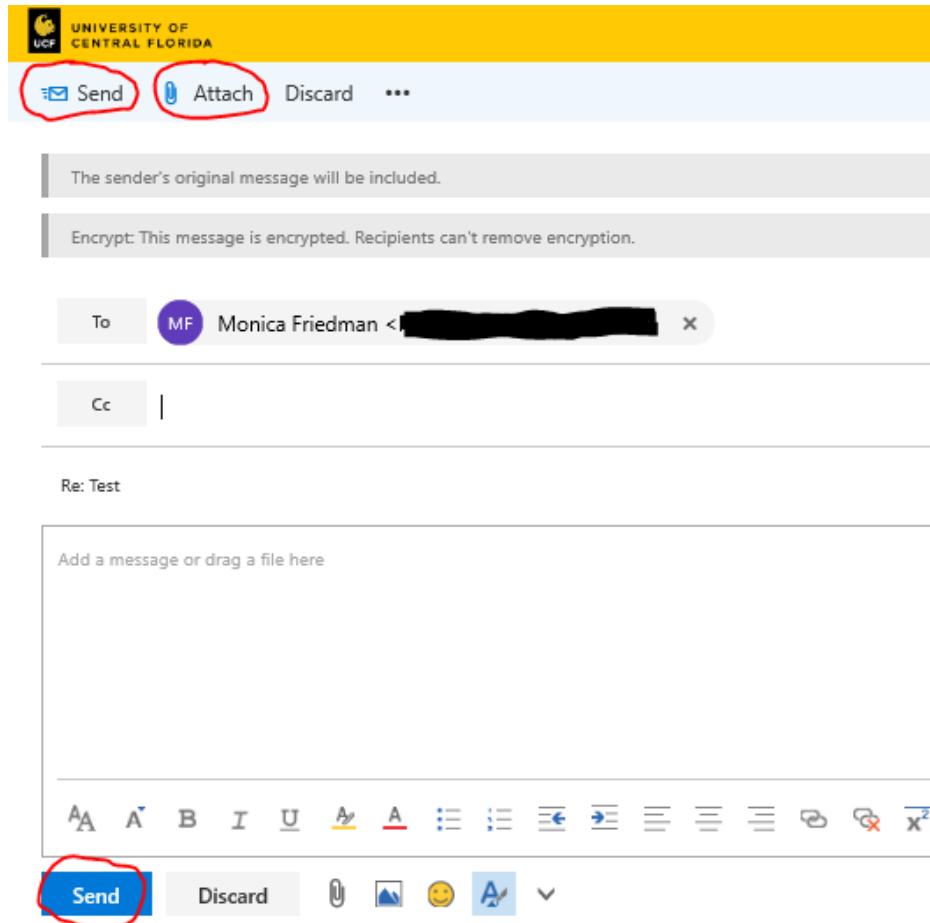
Enter the identity information to be used for creating the self-signed Digital ID.

Digital IDs that are self-signed by individuals do not provide the assurance that the identity information is valid. For this reason they may not be accepted in some use cases.

Name	Monica Friedman
Organizational Unit	Enter Organizational Unit...
Organization Name	Enter Organization Name...
Email Address	monica.friedman@ucf.edu
Country/Region	US - UNITED STATES
Key Algorithm	2048-bit RSA
Use Digital ID for	Digital Signatures

Back Save

- Select "save" and "continue" after entering the required information. Once you press "sign" your electronic signature will populate in the signature field.
- Enter any remaining information (e.g. date, relationship to signer, etc.) by simply selecting the field and typing your responses. Once you have filled out the form completely, save the document to your desired location.
- After saving the completed document, return to your UCF Office 365 Message Encryption Portal to securely return the form to UCF RESTORES. To securely reply, you must re-enter the portal; if you reply to the original email with the link, your reply will **NOT** be encrypted. Reopen the message you wish to respond to, select "reply all", and attach the file to your response message prior to sending.



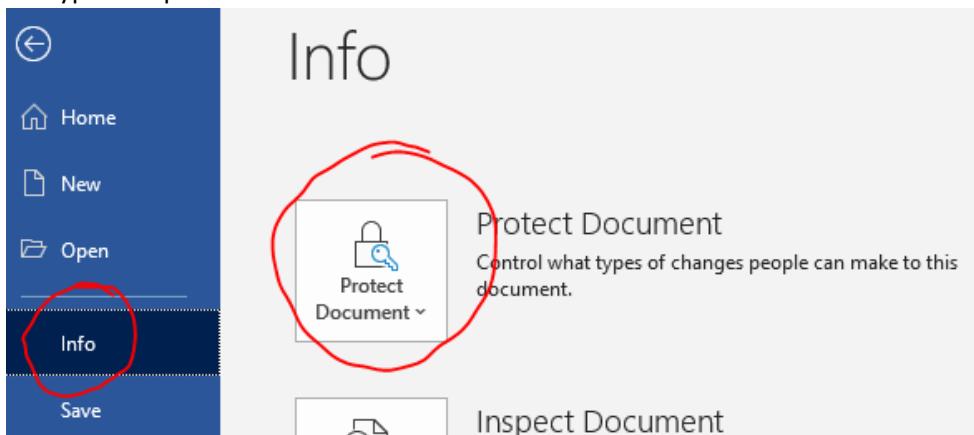
How to Securely Send Documentation Completed by Hand

1. Print attachment(s).
2. Complete each attachment in its entirety.
3. After completing forms by hand, take a photo of the form(s) with your smartphone or camera.
4. Upload the photo(s) to your computer.
5. Once you open the photo (most likely will open as a .JPG), right click the image and select "copy".
6. Open a new document in Microsoft Word and paste the photo by right clicking anywhere in the blank Word document. You can manipulate the size and orientation of the picture by simply selecting the image and moving your mouse over the small circles at each corner of the photo.

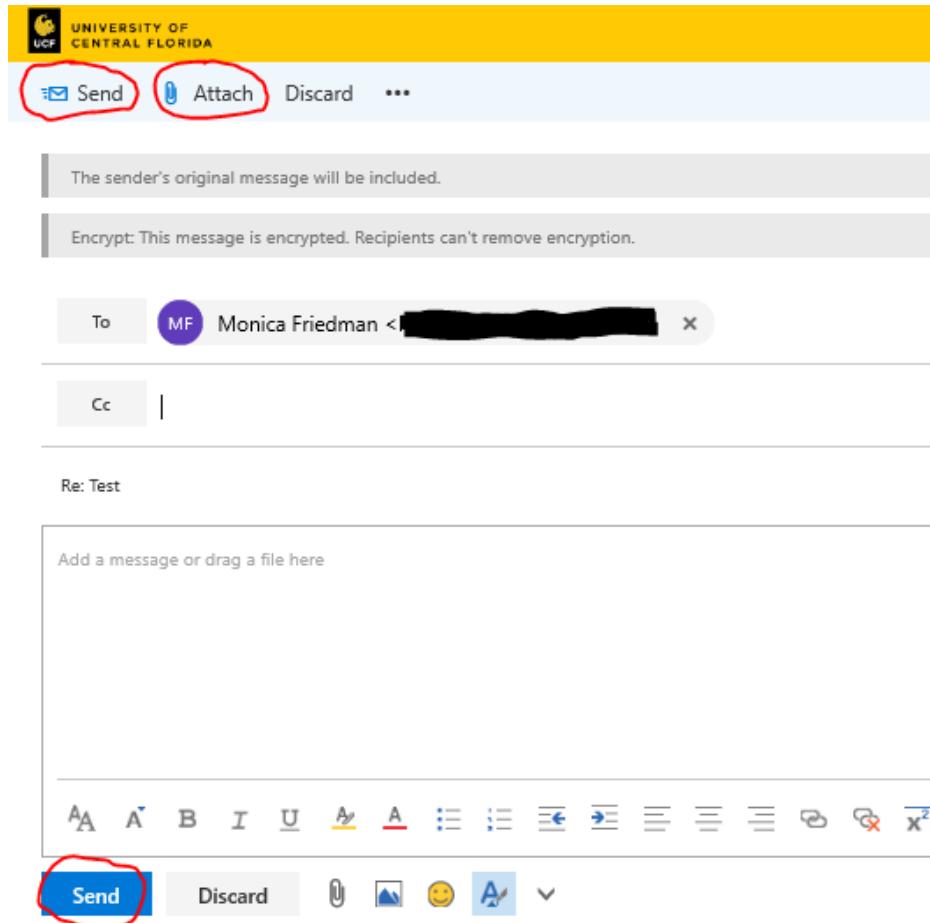


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7. Repeat these steps for every photo you wish to attach as you may have to copy and paste several images depending on the length of the document. An example has been included below.
8. Once you have copied and pasted all desired photos, select file -> info -> protect document -> encrypt with password.



9. In the password field, enter the four digit PIN number you selected during your initial screening with UCF RESTORES.
10. Press save after entering your password.
11. After saving the completed document, return to your UCF Office 365 Message Encryption Portal to securely return the form to UCF RESTORES. Simply reopen the message you wish to respond to, select "reply all", and attach the file to your response message prior to sending. Please be sure to reply to the message within the portal to ensure the email contents remain encrypted.



Example

Demographic Information						
Last name: Doe	First: John	Middle: B				
Street address: 4111 Pictor Ln			Phone number: 407-823-3910			
City: Orlando	State: FL	Zip Code: 32816	Email: abc123@gmail.com			
Birthdate: 1-1-80	Race: B	Age: 40	Gender: Male	License Plate Number: ABC123		
Emergency Contact: Jane Doe			Emergency Contact Phone Number: 407-823-1196			
Relationship Status (circle one): Single In a relationship Living with significant other Engaged Married Separated Divorced						
Education (circle one): Some High School High School Some College Associates Bachelors Masters Doctorate						
Employment (circle one): Employed Employed, on leave Retired Unemployed Disabled Homemaker						
What is your current or most recent job/title? Firefighter						
How long have you worked in this capacity? 15 years						
Have you served in any of the following fields? (circle all that apply) Military Fire Service Law Enforcement EMS/Paramedic Dispatcher Correctional Officer						
Years of military and/or first responder service? 4 yrs mil. 15 yrs fire			Branch and/or department? Marine /UCF Dept.			
Active Duty Military? (circle) Yes or No			If no, years since retirement/separation? 16 years			
Conflict served in? (circle all that apply): Gulf War 1 Gulf War 2 Vietnam OEF OIF OND						
Desert Storm Korean War Other (specify): _____						

Health History		
<i>Please 'check' the statement that best applies:</i>		
<input checked="" type="checkbox"/>	I have never been evaluated for mental health or stress related injuries.	
<input type="checkbox"/>	I have been evaluated, but never treated, for mental health or stress related injuries.	
<input type="checkbox"/>	I have been treated for mental health or stress related injuries.	
<i>I have been diagnosed with (Please circle all that apply):</i>		
Depression	Anxiety	Chronic Medical Condition
Psychosis	Sleep Difficulties	Head Injury with Loss of Consciousness
Alcohol or Drug Disorder(s)	PTSD	Head Injury without Loss of Consciousness
None of these		

<i>Please provide information about physical/medical conditions (i.e., High BP, diabetes, stroke):</i>		
High Blood Pressure		
<i>Please list all medications you are prescribed:</i>		
Lisinopril		
<i>Please list any current treatment and/or mental health services you are receiving:</i>		
None		
<i>Is there any other information you believe is important for us to know?</i>		
Nothing additional to report.		



UCF RESTORES
National Provider Identifier: 1386176097
4111 Pictor Lane, Suite 203
Orlando, FL 32816-1391
Phone: 407-823-3910

Consent for Assessment and Treatment

Services at our clinic are provided by licensed psychologists, licensed clinical social workers, licensed mental health counselors, postdoctoral fellows, registered interns, UCF College of Medicine students, and graduate students in clinical psychology and clinical social work who are supervised by Deborah C. Beidel, Ph.D., ABPP, Sandra M. Neer, Ph.D., Amie R. Newins, Ph.D., and David C. Rozek, Ph.D. UCF RESTORES adheres to all ethical standards of the American Psychological Association and all legal standards of the state of Florida. As prescribed by these standards, all patient information, including your Protected Health Information, is kept strictly confidential and released only with your written permission, with the following exceptions:

- If it is clear that there is immediate danger of physical harm to you or others.
 - If you are an employee of Hillsborough County Sheriff's Office (HCSO) and your provider determines you are an immediate threat to yourself and/or others, the Chief Human Resources Officer at HCSO will be notified.
- If there is reason to believe or suspect that a child, an elderly person, or a disabled person is being abused, abandoned, or neglected.
- If we are ordered by the court to release your records.
- If payment sources request information (e.g., dates of treatment, treatment length, type of treatment, treatment plan, diagnosis, evaluations) for reimbursement of services.

UCF RESTORES is NOT able to provide 24-hour emergency or crisis management services to its clients. If you have an emergency or are in a crisis, call 911 or visit the nearest emergency room.

Your therapist will explain the treatment expectations for your particular treatment plan. It is important to keep your appointments. If you must cancel an appointment, we request that you give us at least 24 hours' notice. We understand that situations such as illness, car trouble, and other emergencies are part of life. However, behavior therapy requires that sessions occur within a specific time period in order for the therapy to be effective. Therefore:

- if you are unable to keep your appointments on a regular basis,
- if you fail to keep more than two appointments without notifying the clinic in advance, or
- if your schedule changes and you are not able to keep appointments during the times our clinic is open,

we may have to refer you to a different service provider. We will assist you to make sure that the transition process is a smooth one. If you have any concerns about the clinic, you can contact the clinic director, Dr. Deborah Beidel, at 407-823-3910.

Behavior therapy involves the application of scientific principles to the treatment of psychological disorders. An important part of behavior therapy is assessing your condition before and after treatment and assessing your progress as you proceed through treatment. In order to assess your progress, we will ask you to fill out surveys and participate in various types of behavioral assessment as long as you are a patient in our clinic. We may use your de-identified information for research activities and reserve the right to examine your data in order to inform ourselves about the clinical effectiveness of our programs, to refine our interventions, and to assist us in the development of new programs.

As a clinical research center, we often conduct treatment research that is funded by federal agencies or private foundations. Furthermore, the graduate students associated with the clinic often conduct research in the clinic that is part of their training to become clinical psychologists. We may contact you in order to describe available research programs that may be of interest to you, but you will never be enrolled in a research program without your permission. Furthermore, you will not be required to enroll in a research program.

I acknowledge that I have read and understand this Consent for Treatment and have had the opportunity to ask any questions. I consent to assessment and treatment at this clinic. I understand that maintaining my appointments is

important for my progress, and I agree to take an active role. I am aware that I can withdraw from therapy at any time without penalty. I understand that I must call to cancel or reschedule appointments at least 24 hours in advance and that failure to do so may result in the termination of service. I recognize that UCF RESTORES is a research facility, and understand that my therapist, Deborah C. Beidel, Ph.D., ABPP, Sandra M. Neer, Ph.D., Amie R. Newins, Ph.D., David C. Rozek, Ph.D. of UCF RESTORES may review all aspects of my treatment. I am aware UCF is an equal opportunity provider and employer.

My signature below indicates that I understand and agree to the above conditions and statements.

Patient Signature	Date	Parent or Legal Guardian Signature	Date
-------------------	------	------------------------------------	------

Witness Signature	Date
-------------------	------

Notice of Policies and Practices to Protect the Privacy of Your Health Information

This notice describes how psychological and medical information about you may be used and disclosed and how you can gain access to this information. It contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law 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. Please review it carefully.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

UCF RESTORES (hereafter referred to as ‘the Clinic’) may *use or disclose your protected health information (PHI)* for *treatment, payment, and health care operations* purposes. To help clarify these terms, here are some definitions:

- “*PHI*” refers to information in your health record that could identify you such as your name, date of birth, phone number, or address.
- “*Treatment, Payment and Health Care Operations*”
 - *Treatment* is when we provide, coordinate or manage your therapy or assessment and other related services. In addition to direct services, this might include such things as consultation with another health care provider, such as your family physician or another psychologist.
 - *Payment* is when we obtain reimbursement for your healthcare, either directly from you or from a third party.
 - *Health Care Operations* are activities that relate to the performance and operation of the Clinic. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and care coordination.
- “*Use*” applies only to activities within the Clinic, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of the Clinic, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

The Clinic may use or disclose PHI for purposes outside of treatment, payment, and health care operations as provided below or when your appropriate authorization is obtained. An “*authorization*” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when the Clinic is asked for information for purposes outside of treatment, payment, and health care operations, an authorization from you will be obtained before releasing this information.

You may cancel all such authorizations at any time, provided each cancellation is in writing. Cancellation of an authorization does not apply to the information that has already been released.

III. Uses and Disclosures with Neither Consent nor Authorization

PHI may be disclosed without your consent or authorization in the following circumstances:

- *Child Abuse*: If there is cause to believe that a child has been, or may be, abused, neglected, sexually abused, or exploited we are legally mandated to make a report of such to the Abuse Hotline operated by the Florida Department of Children and Families.
- *Abuse of a Vulnerable Adult*: If there is cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we are legally mandated to make a report of such to the Abuse Hotline operated by the Florida Department of Children and Families.
- *Health Oversight*: If a complaint is filed against the Clinic or any of its clinicians or supervisors with the State Department of Health or Board of Psychology, the Board has the authority to subpoena confidential mental health information relevant to that complaint and the Clinic is required to respond to the subpoena.

- *Judicial or Administrative Proceedings:* If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged (protected) under state law and will not be released without written authorization from you or your personal or legally appointed representative or a court order. The privilege (protection) does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety:* If it is determined that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, relevant confidential mental health information may be released to medical or law enforcement personnel.
- *Worker's Compensation:* If you file a worker's compensation claim, records relating to your diagnosis and treatment may be disclosed to your employer, employer's insurance carrier, and/or their attorneys.

IV. Patient's Rights and Provider's Duties

Listed below are your rights regarding your health information. Each of these rights are subject to certain requirements, limitations and exceptions. Exercise of these rights may require submitting a written request to UCF RESTORES. At your request, UCF RESTORES will supply you with the appropriate form to complete. Please be aware that uses and disclosures of psychotherapy notes require an authorization. Additionally, certain information (e.g., psychological tests) may not be disclosed except to qualified professionals.

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, the Clinic is 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. (For example, you may not want a family member to know that you are being seen at the Clinic. Upon your request, any communications may be to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. There may be a small charge for copying a record. Your access to PHI may be denied under certain circumstances, but in some cases you may have this decision reviewed. On your request, our staff will discuss with you the details of the request and review process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your request may be denied, but this is also subject to review. On your request, our staff will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, our staff will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of this notice.

Provider's Duties:

- The Clinic is required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI, and to notify you in the event your PHI is breached.
- The Clinic reserves the right to change the privacy policies and practices described in this notice. However, unless you are provided with the updated notice, we are required to abide by the notice currently in effect.

V. Complaints

If you are concerned that anyone at the Clinic has violated your privacy rights, or you disagree with a decision regarding access to your records, you may contact the Clinic Director (Dr. Deborah Beidel, 407-823-3910 Deborah.Beidel@ucf.edu) or the Florida Department of Health Division of Medical Quality Assurance (850-245-4339 or http://www.floridahealth.gov/licensing-and-regulation/enforcement/_documents/frm-psyucf.pdf.)

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person or agency listed above can provide you with the appropriate address upon request. You will not be retaliated against for filing a complaint.

VI. Civil Rights Notice

In accordance with federal law and U.S. Department of Justice policy, this organization is prohibited from discriminating on the basis of race, color, national origin, religion, sex, age, or disability. To file a complaint of discrimination, write the Florida Department of Legal Affairs, Federal Discrimination Complaint Coordinator, PL-01 The Capitol, Tallahassee, Florida, 32399-1050, or call 850-414-3300, or write Office for Civil Rights, Office of Justice Programs, U.S. Department of Justice, 810 7th Street, NW, Washington, DC 20531 or call 202-307-0690 (Voice) or 202-307-2027 (TDD/TYY). Individuals who are hearing impaired or have speech disabilities may also contact OCR through the Federal Relay Service at 800-877-8339 (TTY), 877-877-8982 (Speech), or 800-845-6136 (Spanish).

VII. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on May 2, 2016.

UCF RESTORES reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that is maintained. You will be provided with a revised notice in person or by mail (or email if appropriate) prior to the revisions taking effect.

I have received a copy of the UCF RESTORES **Notice of Policies and Practices to Protect the Privacy of Your Health Information** and have been given the opportunity to ask questions and all of my questions have been satisfactorily answered.

Signature

Date

Relationship to Patient

Can we leave phone messages regarding appointment scheduling? YES NO

If yes, at what phone number(s) can we leave messages? _____



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4111 Pictor Lane, Suite 203
Psychology Building
Orlando, FL 32816-2385

UCF RESTORES Consent for Telehealth Services

This Informed Consent for Telehealth contains important information focusing on doing psychotherapy using audio/video through the phone or the Internet. Please read this carefully and contact your provider at 407-823-3910 with any questions. When you sign this document, it will represent an agreement between you and UCF RESTORES to participate in video sessions. This consent is in addition to, and does not replace, the Consent for Assessment and Treatment previously signed by you.

Benefits and Risks of Telehealth

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

- **Risks to confidentiality.** Because telehealth 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. UCF RESTORES will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our 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 telehealth. 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.** UCF RESTORES will not engage in telehealth with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telehealth, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telehealth work.
- **Efficacy.** Most research shows that telehealth is about as effective as in-person psychotherapy.

Information about Telehealth

Video conferencing is an option for conducting remote sessions over the internet where you will be able to speak to and see your therapist on a screen. At the UCF RESTORES, we use Zoom for Healthcare as a secure video conferencing platform. If you and your therapist choose to utilize this technology, your therapist will give you detailed directions regarding how to log-in securely.

We ask that you please sign on to the platform at least five minutes prior to your session time to ensure you and your therapist are able to start promptly. If you need to reschedule your session, please contact your clinician in advance at the number they provided.

We strongly suggest that you only engage in video conferencing sessions through a computer or device that you know is secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network).

Patients are prohibited from recording these sessions. UCF RESTORES may record sessions as noted in the UCF RESTORES Consent for Assessment and Treatment.

The following information pertains specifically to the use of **video conferencing**. Use of videoconferencing is completely voluntary.

- Zoom for Healthcare is an online communication tool allowing for face-to-face video and it is **HIPAA compliant**. For more information about Zoom for Healthcare security and privacy, please see: <https://zoom.us/docs/doc/Zoom-hipaa.pdf>
- Appointments will be made via phone or at the end of your session. The invite to the meeting will be emailed to you. Please let your provider know if email communication is not acceptable. Please be online at least five minutes prior to session, alone, in a quiet room, with the door closed.
- I understand that I need a device with a webcam and microphone for these sessions, and I understand that it is my responsibility to obtain the necessary technology for me to participate in these sessions.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- For best picture and audio quality, a hardwired connection (via LAN cable) rather than a wireless one should be used if possible. Headphones add additional privacy.
- I agree to work with my clinician to come up with a safety plan, including identifying one or two emergency contacts, in the event of a crisis situation during our sessions.
- Video sessions should be treated like an in-office session: no outside distractions, turn off cell phones, close other programs on your computer, and be on time. The limits to confidentiality outlined in the UCF RESTORES Consent for Assessment and Treatment and Notice of Policies and Practices to Protect the Privacy of Your Health Information also apply to telehealth sessions.
- I understand that UCF RESTORES may decide to terminate video therapy services, if they deem it inappropriate for me to continue therapy through video sessions. Additionally, I understand that these video sessions are being made available on a temporary basis and I may be expected to return to in-person sessions when UCF RESTORES resumes normal clinic operations following the clinic closure related to COVID-19.

I also understand the following limitations of Zoom for Healthcare video therapy sessions:

- Any internet-based communication is not 100% guaranteed to be secure/confidential. I agree that the UCF RESTORES should not be held responsible if any outside party gains access to the video feed.
- In a crisis or emergency situation that needs immediate attention, or if I am considering seriously harming myself or someone else, I will dial 911, or go to a mental health hospital/ER.
- Technical problems could occur. If the call is disrupted, both the clinician and I will attempt to rejoin the meeting within ten minutes. If reconnection cannot occur, the session may be rescheduled.

I have been informed of and understand the risks and procedures involved with using the videoconferencing technology. I agree to the terms listed above and I hereby voluntarily consent to the use of this platform for therapy sessions with my provider. I agree that UCF RESTORES should not be held liable in the event that any outside party passes technology security and discovers personal or confidential information. This consent will last for the duration of the relationship with this clinic unless I withdraw my consent for video sessions; I can withdraw my consent for a video therapy session in writing at any time, and UCF RESTORES will work with me to find a suitable alternative.

Patient Name: _____ Date of Birth: _____

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____



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UCF RESTORES Patient Telehealth Information Form

At the outset of telehealth services, this form must be completed. Provided information must be accurate, may be verified by the provider or another appointed designee through the organization, and will be utilized to ensure the safety of all parties. If the treating provider determines there is a justifiable reason to break confidentiality to ensure the safety of the patient or another person due to the patient's behavior, the provider is authorized to do so. Conditions for breaking confidentiality may include, but are not limited to: if the patient is determined to be an active harm to themselves or to another, if abuse is recognized, or for a medical or behavioral emergency. If confidentiality must be broken, the treating provider will make reasonable efforts to inform the patient prior to or following the disclosure, as allowed.

General Contact Information:

Patient Name: _____

Patient Home Address: _____

Best Phone Number to Reach Patient: _____

Emergency Contact Information:

Best Alternative Contact Person 1: _____

Relationship to Patient _____

Best Phone Number to Reach: _____

Best Alternative Contact Person 2: _____

Relationship to Patient _____

Best Phone Number to Reach: _____

Nearest Medical Center Name: _____

Nearest Medical Center Address: _____

Nearest Medical Center Phone Number: _____

Nearest Police Department Name: _____

Nearest Police Department Address: _____

Nearest Police Department Phone Number: _____

Emergency Plan:

- If there appears to be a possibility of harm to the patient or to another person, the patient/family is to immediately go to the local medical center/emergency room listed on this form. They are asked to contact the provider after safety has been ensured. If the patient/family is closer to another medical center than what is listed, they are to go to that location. Following stabilization and discharge, the patient/family is to provide the provider with an indication of what led to the need for a hospital visit, details of the hospital stay (e.g., medications, diagnoses, treatment summary), and both emotional and behavioral status post-discharge.
- Note: At any time, the provider can decide that telehealth services are no longer appropriate and as such, may be terminated. If such an event occurs, the provider will provide alternative referral options should face-to-face treatment not be possible.

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Provider Printed Name: _____

Provider Signature: _____ Date: _____