ON POINT
PERFORMANCE NEURO TRAINING

THERAPY DISCLOSURE STATEMENT
NOTICE OF SERVICES, POLICIES & PRACTICES

Welcome,

Thank you for considering On Point's services. In order to help you make an informed decision, please review this statement in its entirety and sign it in the space provided. If you have any questions or concerns, we would be pleased to discuss them with you.

Educational Attainment

- **Certified Light Therapist.** Quantum Academy: **2016**
- **Certified Brainspotting Levels I, II, III & Masters Training:** International Brainspotting **2012, 2014 & 2015**
- **Masters of Social Work Degree:** ***Advanced Generalist***: Colorado State University **2013**
- **Certified Mediator**: Colorado State University **2013**
- **Bachelors of Arts Degree Human Performance and Wellness**: ***Exercise Science***-Colorado Mesa University **2005**

Professional Affiliations

- **Concussion Legacy Foundation Ambassador 2016-current**
- **Rocky Mountain Brainspotting Institute 2015-current**
- **National Association of Social Workers 2014-current**
- **International Brainspotting 2012-current**
- **Gamma Beta Phi National Collegiate Honor Society**
  CSU Department of Food Science and Human Nutrition **2012-current**
- **Phi Alpha National Collegiate Honor Society** Chapter: **Theta Pi**
  CSU School of Social Work **2011-current**

Psychotherapies Utilized

- Cognitive Behavior Therapy
- Interpersonal Therapy
- Psychoanalytic Therapy
- Dialectal Behavior Therapy
- Brainspotting

Licenses

Colorado-Licensed Clinical Social Worker (License # CSW 09925343) status are persons in the field of psychotherapy regulated by the Mental Health Licensing Section of the Division of Professions and Occupations. The Board of Social Work can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800. As a Licensed Clinical Social Worker I am listed in the State's database and I am authorized by law to practice psychotherapy in Colorado. As to the regulatory requirements applicable to mental health professionals:

- ✓ *The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The board of Licensed Professional Counselors Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894.7800.*

- ✓ *The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The board of Licensed Marriage and Family Therapy Examiners can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80302, (303) 894.7800.*
- ✓ *The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. The Board of Certified Addictions Counselor III (CAC III) can be reached at 1560 Broadway, Suite 1350, Denver, Colorado 80302, (303) 894.7800.*
- ✓ *Registered psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.*
- ✓ *Certified Addiction Counselor I (CAC I) must be a high school graduate, complete required training hours and 1,000 hours of supervised experience.*
- ✓ *Certified Addiction Counselor II (CAC II) must complete additional required training hours and 2,000 hours of supervised experience.*
- ✓ *Certified Addiction Counselor III (CAC III) must have a bachelors degree in behavioral health, complete additional required training hours and 2,000 hours of supervised experience.*
- ✓ *Licensed Addition Counselor must have a clinical masters degree and meet the CAC III requirements.*
- ✓ *Licensed Social Worker must hold a masters degree in social work.*
- ✓ *Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.*
- ✓ *Licensed Clinical Social Worker, a Licensed Marriage and Family Therapist, and a Licensed Professional Counselor must hold a masters degree in their profession and have two years of post-masters supervision.*
- ✓ *A Licensed Psychologist must hold a doctorate degree in psychology and have one year of post-doctoral supervision.*

Colorado-Confidentiality

Generally Speaking the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes and the HIPAA Notice of Primacy Rights you were provided as well as other exceptions in Colorado and Federal law. If a legal exception arises during therapy, if feasible, you will be informed accordingly. The Mental Health Practice Act (CRS 12-43-101, et seq.) is available at: http://www.dora.colorado.gov/professions/registeredpsychotherapists.

For example, some of the exceptions would include: suspected child abuse, molestation or incest, a client is in danger of hurting self or others, danger of violence, suspected abuse of the elderly or others unable to care for themselves, suspected threat to national security, subpoenaed testimony in criminal court cases, orders to violate privilege by judges in child custody and divorce cases. When treating couples or families, confidentiality among family members is not a guarantee.

There may be times when I need to consult with a colleague or another professional about issues raised by clients in therapy. Client confidentiality is still protected during consultation by me and the professional consulted. Signing this disclosure statement gives me permission to consult as needed to provide professional services to you as a client.

Washington-Licensed Independent Clinical Social Worker Associate (License # SC6067184) under supervision in the State of Washington. I am listed in the State of Washington database and I am authorized by law to practice

psychotherapy in the State of Washington as a Licensed Independent Clinical Social Worker Associate and I am required to have a Masters degree in Social Work. As to the regulatory requirements applicable to mental health professionals:

- ✓ *Licensed Independent Clinical Social Worker Associates in the State of Washington must hold a Masters degree in their profession and must be participating in at a minimum of 3 years of post-masters supervision under an approved and supervisory trained Licensed Independent Clinical Social Worker.*

Washington-Confidentiality

All information discussed with In-Sight is strictly confidential in nature and shall be used solely by In-Sight professionals. This information will not be disclosed or released without written permission of the client, and will be done in a manner consistent with In-Sight information handling procedures. If an In-Sight professional believes there is a physical threat to a client or someone named by a client, state and federal law require disclosure of that information. In compliance with Washington State law (RCW 18.225.105), information shall only be disclosed under the following circumstances:

(1) With the written authorization of that person or, in the case of death or disability, the person's personal representative
(2) As required under chapter 26.44 or 74.34 RCW or RCW 71.05.250; or [abuse/neglect, harm to self/others]
(3) To any individual if the person licensed under this chapter reasonably believes that disclosure will avoid or minimize an imminent danger to the health or safety of the individual or any other individual; however, there is no obligation on the part of the provider to so disclose.
(4) If the person waives the privilege by bringing charges against the person licensed under this chapter;
(5) In response to a subpoena from the Secretary of Health. The secretary may subpoena only records related to a complaint or report under RCW 18.130.050

Fees and Payment Policies

Individual psychotherapeutic sessions are $150/60 minute session. Individual Performance Neuro Training sessions are $150/60 minute session. Phone calls or text communications over 5 minutes will be pro-rated ($15.00/5 minutes) and will be billed to the client. Additional documentation required by the client will also be carry a service fee ($100/60 minutes) according to the time required by On Point to produce the document and will be billed to the client. On Point does not voluntarily participate in any legal proceedings. There is a fee of $200/60 minutes of preparation/participation in any legal proceedings. Travel costs must also be covered, should our clinician be required to attend proceedings. Payments are due online prior to each session; exceptions to this will only be permitted following specific arrangements agreed upon between the client and provider. 24 hours notice is required to cancel a session without full service charge. We do not bill medical insurance for services.

Client Rights & Responsibility

Effective psychotherapy requires active participation, honesty, and a commitment to engaging with your thoughts/feelings/behaviors. A trusting relationship between client and therapist is essential to the therapeutic process. Clients have the right to choose a practitioner and treatment modality that best suits their needs. Each client has the right to refuse treatment, at any time. In addition, they have Each client has a legal right to obtain list of, or copy, the acts of unprofessional conduct listed under RCW 18.130.180. This document can be requested from the following address:
Health Professions Quality Assurance Customer Service Center PO Box 47865 Olympia, WA 98504
Email: hpqa.csc@doh.wa.gov ***Phone:*** **(360) 236-4700 Fax: (360) 236-4818**

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Acknowledgement

I have read the proceeding information, it has been provided verbally, and I understand my rights as a client or as the client's responsible party. Therefore, I understand this therapy disclosure statement and its content. I also acknowledge receiving a copy of this statement. I have been provided with a fee agreement stating the agreed cost of therapy and or mediation sessions and agree to the terms listed above and agree to pay for services rendered regarding payment.

Client Name (Printed):

_____ **Date**:_____

***Responsible Party Name (Printed)**:

_____ **Date**:_____

Relationship to client & Authority to Consent:

_____

Client Signature:

_____ **Date**:_____

(*Responsible party if client is a minor)

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CLIENT INTAKE FORM

_____

(Last) (First) (Middle Initial)

Name of Client parent/guardian (if under 18 years):

_____

(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____

Sex/Gender: □ Male □ Female □ Transgender

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated □ Divorced □ Widowed

Home Phone: ( ) Cell Phone: ( )

Physical Address:

_____

_____

(City) (State) (Zip)

Mailing Address *(if different from physical)*:

_____

_____

(City) (State) (Zip)

Referred by (if any):
_____

Are you currently taking any prescription medication?
□ Yes
□ No
Please list: _____

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GENERAL HEALTH AND MENTAL HEALTH INFORMATION

How would you rate your current physical health? (please circle)

1 2 3 4 5 6 7 8 9 10

Please list any specific health problems you are currently experiencing:

_____

_____

How would you rate your current sleeping habits? (please circle)

1 2 3 4 5 6 7 8 9 10

Are you experiencing a significant loss or grief?
□ No
□ Yes
If yes, when did you begin experiencing this? _____

Are you experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes
If yes, how often? □ Daily □ Weekly □ Monthly
For approximately how long? _____

Are you currently experiencing any chronic or frequent pain?
□ No
□ Yes
If yes, please describe? _____

Do you drink alcohol?
□ No
□ Yes
If yes, how often? □ Daily □ Weekly □ Monthly

Do you engage in recreational drug use (Marijuana in any form)?
□ No
□ Yes
If yes, how often? □ Daily □ Weekly □ Monthly

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All of the information provided on this form as well as any information shared during the therapeutic process/session(s) will remain completely private and confidential. The information on this form and or any other information will only be released upon a written request from the client as consented from the client.

Client Name (Printed):

_____ **Date**:_____

***Responsible Party Name (Printed)**:

_____ **Date**:_____

***Relationship to client & Authority to Consent**:

_____

Client Signature:

_____ **Date**:_____

(*Responsible party if client is a minor)

Thank you for sharing!

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THERAPIST ADMINISTERED ASSESMENT

Sport you compete in:
_____

Sports Injuries MAJOR & MINOR including not limited to: strains, sprains, tendonitis, shin splints, broken/bruised bones, stress fractures, torn ligaments, torn tendons, torn joint capsules, ANYTHING requiring surgeries or physical therapy)
AGES 3-10

AGES 11-18

AGES 19-26

AGES 27-34

AGES 35-42

Concussion(s) Mechanism of Injury and Major (LOC) or Minor (NO LOC)
AGES <5_____AGES 5-10_____

AGES 11-16_____

AGES 17-22_____

AGES 23-28_____

AGES 29+_____

What are your identified goals related to Sports Performance
1)

2)

3

SPORTS PERFOMANCE & LIFE TRAUMAS LIST

To begin your Brainspotting session I will ask you to disclose if you have had any of these circumstances/"Trigger Events" at ANY point in YOUR Sports Career:

- Poor performance, or perceived “poor” performance by the athlete?
- Conflicts with coaches or teammates?
- An illness, resulting in a loss of playing time or surgery?
- Significant Changes in Game Schedules or Practice Schedules, Travel or are Currently having to Move?
- Lack of playing time?
- Family and or relationship issues?
- Changes in importance of sport, expectations by self, role of sport in life?
- Violence — being assaulted, a victim of domestic violence, automobile accidents, or merely witnessing a personal injury or assault on a family member, friend or teammate?
- Challenges with Adapting to a professional athlete lifestyle?
- Death of a loved one or close friend?
- Alcohol or drug abuse?
- Significant dieting or weight loss?

- History of physical or sexual abuse?

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Neuro Cognitive Assessment as Specified by the *Diagnostic and Statistical Manuel of Mental Disorders Fifth Edition* (DSM-5). (American Psychological Association, p.591-595, 2013). Fill in as much as possible.. Thanks!

Is there a history of mental illness in your family?_____

Have you been diagnosed with a mental illness?_____

Do they use any substance(s) (drugs, alcohol, herbs and or prescription medication?

_____

_____

Neurocognitive Domains:

Symptoms or Observations-

Cognitive Domain-*Complex Attention*

Moderate-

1. Increased difficulty in environments with multiple stimuli (TV, radio, conversation); is easily distracted by competing events in the environment.
   No____ Yes _____
   _____
2. Is unable to attend unless input is restricted and simplified.
   No____ Yes _____
   _____
3. Has difficulty holding new information in mind, such as recalling phone numbers or addresses just given, reporting what was just said.
   No____ Yes _____
   _____
4. Is unable to perform mental calculations.
   No____ Yes _____
   _____
5. Thinking takes longer than usual and components to be processed must be simplified to one or a few.
   No____ Yes _____
   _____

Mild-

1. Normal tasks take longer than previously.
   No____ Yes _____
   _____
2. Begins to find errors in routine tasks; finds work needs more double checking than previously.
   No____ Yes _____
   _____
3. Thinking is easier when not competing with other things (radio, TV, other conversations, cell phone, driving)

No____ Yes _____
_____

Cognitive Domain Exercises: *Complex Attention*

4. Sustained Attention: Press a button every time a tone is heard
5. Divided Attention: Competing stimuli- read only numbers on a page where letters are present as well.
6. Selective Attention: Two tasks within the same time period-have the individual tap a button while concurrently learning a story being read.
7. Processing Speed: Timed activity such as putting together a puzzle or the King Devicks test.

Cognitive Domain: Executive Functioning

Moderate-

1. Abandons Complex projects
   No____ Yes _____
   _____
2. Needs to focus on one task at a time
   No____ Yes _____
   _____
3. Needs to rely on others to plan instrumental activities of daily living or make decisions
   No____ Yes
   _____
   _____

Mild-

1. Increased effort required to complete multistage projects.
   No____ Yes _____
   _____
2. Has increased difficulty multitasking or difficulty resuming a task interrupted by a visitor or phone call.
   No____ Yes
   _____
   _____
3. May complain of increased fatigue from the extra effort required to organize, plan and make decisions.
   No____ Yes _____
   _____
4. May report that large social gatherings are more taxing or less enjoyable because of increased effort required to follow shifting conversations.
   No____ Yes
   _____
   _____

Cognitive Domain Exercises-Executive Functioning

1. **Planning:** Ability to find the exit to a maze or interpret a sequential picture or object arrangement.
2. **Decision Making:** Multiple option activity such as simulated gambling
3. **Working memory:** Ability to hold information for a brief period of time. Add a group of numbers and then manipulate them.
4. **Feedback/error utilization:** Benefit from feedback to infer the rules of solving a problem. Give a situation or problem which needs solving and then latter in the conversation give additional information which would assist the solving of the problem to see if the information will be used or be ignored to solve the problem.
5. **Overriding Habits/inhibition:** Ability to choose a more complex and effortless solution to be correct. Ability to name the color of a color's font rather than the color named.
6. **Mental/cognition flexibility:** Ability to shift between two concepts. Order shapes by the shape and then shift to ordering the shapes colors by the color of the shape. Order numbers from highest to lowest or from lowest to highest.

Cognitive Domain-Learning and Memory-

Moderate-

1. **Repeats self often within the same conversation.**
   No____ Yes _____
   _____
2. **Cannot keep track of short list of items when shopping or of plans for the day.**
   No____ Yes _____
   _____
3. **Requires frequent reminders to orient to task at hand.**
   No____ Yes _____
   _____

Mild-

1. Has difficulty recalling recent events, and relies increasingly on list making or calendar.
   No____ Yes _____
   _____
2. Needs occasional reminders or re-reading to keep track of characters in a movie or novel.
   No____ Yes _____
   _____
3. Occasionally may repeat self over a few weeks to the same person.
   No____ Yes _____
   _____
4. Loses track of whether bills have already been paid.
   No____ Yes _____
   _____

Cognitive Domain Exercises-Learning and Memory:

1. **Immediate memory span**: Ability to repeat a list of words or digits.

2. **Recent memory**: Asked to repeat a list of word just read to them, Ability to recall names of characters form a story just read or heard. Ability to recall items on a list just read.

Cognitive Domain-Language

Moderate-

1. Has significate difficulties with expressive or receptive language-Often uses general-use phrases such as "that thing" and "you know what I mean," prefers general pronouns rather than names.
   No____ Yes _____
   _____
2. With severe impairment may not even recall names of closer friends and family.
   No____ Yes _____
   _____
3. Idiosyncratic word usage, grammatical errors, and spontaneity of output of economy of utterances occur.
   No____ Yes _____
   _____
4. Stereotypy of speech occurs; echolalia and automatic speech typically precede mutism.
   No____ Yes _____
   _____

Mild-

1. Has noticeable word-finding difficulty.
   No____ Yes _____
   _____
2. May substitute general for specific terms.
   No____ Yes _____
   _____
3. May avoid use of specific names of acquaintances.
   No____ Yes _____
   _____
4. Grammatical errors involves subtle omission or incorrect use or articles, prepositions, auxiliary verbs, etc.
   No____ Yes _____
   _____

Cognitive Domain Exercises-Language:

1. **Expressive Language:** Confrontational naming-listing as many words starting with the letter "L".
2. **Grammar and Syntax:** Omission or incorrect use of articles, prepositions and auxiliary verbs observed within tests and or dialogue.
3. **Receptive Language:** Comprehension and performance of actions/activities according to verbal commands.

Cognitive Domain-Perceptual Motor-

Moderate-

1. Has significate difficulties with previously familiar activities, navigating in familiar environments, is often more confused at dusk, when shadows and lowering levels of light change perceptions.
   No____ Yes _____
   _____

Mild-

1. May need to rely more on maps or others for directions.
   No____ Yes _____
   _____
2. Uses notes and follows others to get to a new place.
   No____ Yes _____
   _____
3. May find self lost of turned around when not concentrating on task.
   No____ Yes _____
   _____
4. Is less precise in parking
   No____ Yes _____
   _____
5. Needs to expend greater effort for spatial tasks such as carpentry, assembly, sewing or knitting.
   No____ Yes _____
   _____

Cognitive Domain Exercises-Perceptual Motor:

1. **Visual Perception:** Identification of matching figures which are the same or not.
2. **Visuoconstructional:** Assembly of items requiring eye hand coordination-drawing or copying and block assembly.
3. **Perceptual-motor:** Integrate perception with purposeful movement
4. **Praxis:** Ability to imitate gestures or pantomime use of objects to command (show me how you use a hammer).
5. **Gnosis:** Perceptual integrity of awareness and recognition, such as recognition of faces and colors.

Cognitive Domain-Social Cognition

Moderate-

1. Behavior clearly out of social range; shows insensitivity to social standards of modesty in dress or of political, religious, or sexual topics of conversation.
   No____ Yes _____
   _____

2. Focuses excessively on a topic despite group's disinterest or direct feedback.
   No____ Yes _____
   _____
3. Behavioral intention without regard to family or friends.
   No____ Yes _____
   _____
4. Makes decisions without regard to safety (inappropriate clothing for situation, social setting or weather) typically has little insight into these changes.
   No____ Yes _____
   _____

Mild-

1. Has subtle changes in behavior or attitude, often described as a change in personality, such as less ability to recognize social cues or read facial expressions, decreased empathy, increased extraversion or introversion, decreased inhibition, or subtle or episodic apathy or restlessness.
   No____ Yes _____
   _____

Cognitive Domain Exercises-Social Cognition

1. **Recognition of emotions:** Recognition of positive and negative facial expressions.
2. **Theory of mind:** Ability to consider someone else's mental state or experience based off story cards with questions like "Why is the boy sad?" Where will the girl look for the bag?"

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Low Level Laser & Light Therapy Informed Consent

Date_____
Name: (Print) _____
Address: _____City: _____
State: _____ Zip: _____ Cell Phone: _____
Email: _____Referred by: _____

Credentials: I understand that Paige E. Roberts is a Certified Light Therapist providing light therapy services and is not a medical doctor.

Disclaimer: I understand that Paige E. Roberts is not a licensed physician and is not licensed to diagnose or treat specific diseases. If a medical diagnosis or treatment is required, it must be obtained from a licensed physician.

Scope of Practice: Light Therapy is a process whereby the device emits a bandwidth of light to certain parts of the body thereby helping repair damaged cells. Light radiation must be adsorbed to produce biological responses such as pain reduction and increased circulation. I understand that light therapy is only being utilized for the purpose of pain reduction and increasing localized circulation, as per the device's FDA clearance. It is not intended to treat or cure any disease.

Permissions:
1. I acknowledge that at times the therapist will need to apply the light to my body. I give permission for **"hands-on-my-body"** assistance. initial_____
2. I am aware that the at times improved circulation **may result in a temporary increase** in pain/discomfort. I give permission **to go forward** with the Light Therapy. initial _____
3. Client feedback regarding symptoms, severity/improvement, location of pain/discomfort, and quality of life issues will be helpful. I acknowledge that **feedback is voluntary and welcomed**. initial _____

Benefits: The expected benefits from undergoing light therapy for areas upon which light therapy include pain reduction and localized increase in circulation.

Contraindications: Light therapy is non-invasive. It is important to notify the practitioner if your medical history changes such as becoming pregnant or if you have been diagnosed with an unexpected medical condition.

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Please answer the following questions.

Do you have any of the following conditions:	
Yes__ / No__	Do you have chronic low blood pressure?
Yes__ / No__	Do you have a history of epilepsy?
Yes__ / No__	Do you have an active carcinoma?
Yes__ / No__	Do you take blood thinners?
Yes__ / No__	Do you take nitrates such as nitroglycerin?
Yes__ / No__	Do you have any areas of malignant tissue?
Yes__ / No__	Do you have any areas of hemorrhage?
Yes__ / No__	Do you have any areas of active bleeding?
Yes__ / No__	Are you currently pregnant or breastfeeding?
If you answered yes to any of the above questions, then you are not a candidate for Light Therapy.	
Yes__ / No__	Do you have any contagious or infectious conditions
Yes__ / No__ Initial_____	**Do you wish to proceed** even though you may not be a candidate for Light Therapy because of _____ I understand the risk and hold harmless all associated with me using Light Therapy. Signature:_____date_____

Confidentiality: Client information will be kept in confidence and will not be disclosed to anyone outside of this office without your written consent, unless required by law. Do you wish to sign a consent for the purpose of sharing your experience with light therapy with others. Yes / No if Yes an additional form will be provided.

Arbitration: Any dispute, controversy or claim arising out of or relating to these services shall be exclusively resolved by binding arbitration upon a party's submission of the dispute to arbitration, with arbitration fees to be shared proportionally between the parties.

Consent: By signing below, I agree that I have read and understand the above information. My questions have been fully answered to my satisfaction, and I have made an informed decision to undergo light therapy.

_____ _____ _____

Client Signature Print Name Date

Consent for Parents/Guardians of Minor Client

I attest that I have full legal authority to make decisions for the minor named below, and that I give my permission for him/her to undergo light therapy.

_____ _____ _____

Parent /Guardian Signature Print Name Date

_____ _____ _____

Name of Minor Client Date of Birth

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Telehealth Session Information

What you will need for the session-

- Computer or IPad with audio and video capabilities
- Phone with downloadable music capabilities
- Head phones
- An eye patch (the kind you purchase from the drug store)

So you will need the Biolateral sound to listen to through headphones on your iPhone or phone.. There are a couple of ways of obtaining the biolateral sound track.

- http://www.bspuk.co.uk/bspuk-free-music-downloads/

Also the Itunes has Dr. David Grand's Biolateral sounds and I have clients download and pay for just the one song "seas of change" or "oceanic feelings" It's ocean sounds

Also there are a few options in deciding what form of teleconferencing you want to use.

There's Zoom conferencing
Can be used on an Ipad (there's an app) and a computer
https://zoom.us/pricing

Create a free account using the same email you provided for me to contact you because once you tell me you have downloaded the free account I will send you an email request for the meeting. You will accept the request and it will be listed under your meetings on your account. When it is time for the meeting you simply go into your account and click on your meetings and say join meeting.

There's Facetime
Can be used on an Ipad and Mac book

My Ipad is linked to my cell number-
970.875.4591

There's Skype
Can be used on an Ipad (there's an app), or computer.

My skype handle is-
paigee.roberts2

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