Depression Anxiety & Wellness Center

INFORMED CONSENT TO TELEHEALTH

Telehealth involves the real-time evaluation, diagnosis, psychotherapy, and treatment of a health condition using advanced telecommunications technology, which may include the use of interactive audio, video, or other electronic media. As such, telehealth allows the provider to see and communicate with the client in real-time.
Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment.

Consent for Treatment. I hereby consent to participating in psychotherapy via internet (hereinafter referred to as Telehealth) with the clinician listed below:

Client Name:____

Client Physical Address :____City_________________________

State: Texas Zip_________________

Client Phone: ____

Clinician: ____

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

By law, there are, exceptions to confidentiality. These including (1) mandatory reporting of child, elder, and dependent disabled adult abuse, (2) any threats of violence with intent to do serious harm or cause death to self or others. I understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. I understand that my therapist is required by law to report abuse, of children, elderly or disabled persons. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I acknowledge that Depression Anxiety & Wellness Center Providers' advice, recommendations, and/or decision may be based on factors not within their control, such as incomplete or inaccurate or incomplete data provided by me or distortions of diagnostic information or images that may result from electronic transmissions. I acknowledge that it is my responsibility to provide my therapist with information about my current location at the time of services, medical, mental health history, substance abuse history, condition and care that is complete and accurate to the best of my ability.

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I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. Although precautions are taken to protect the confidentiality of this information by preventing unauthorized review, I understand that the telehealth audio, data, video electronic transmission of data, video images, and audio meets the HIPAA guidelines , however new and developing technology has risks and that confidentiality may be compromised by failures of security safeguards or illegal and improper tampering.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents.

In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, my therapist will ask the client to seek in person treatment. I will be referred to a therapist in my geographic area that can provide such services.

I am fully informed of the consequences, benefits, and risks of treatment, and I have the right to decline telehealth services.
The executed Telehealth Informed Consent form is a part of the patient's electronic medical record.

I understand my provider will break confidentiality and has the duty to take serious threats of harm to self and others seriously and will call 911, or the local authorities to prevent the threatened danger.

As a client, I can ask questions prior to signing the consent form.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction. I have the right to discontinue telehealth sessions at any time during the session.

I understand that I can withdraw my consent to Telehealth communications by providing written notification to Depression Anxiety & Wellness Center 303 Longmire Rd Suite 701, Conroe Texas 77304.

My signature below indicates that I have read this Agreement and agree to its terms.

____ ____________________

Client Authorized Signature **Date**

____ ____________________

Client Printed Name **Date**

____ ____________________

(If minor) Signature of Responsible Party (Relationship to Client) Date

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Therapist Signature **Date**

Depression Anxiety & Wellness Center
303 Longmire Rd. Suite 701
Conroe, Texas 77304
Phone: 936.647.1188 Fax: 936.647.1212
Governed by Texas State Board of Examiners of Professional Counselors: TX Department of State Health
` Services Mail Code 1982 PO Box 149347 Austin, Texas 78714-9347

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Credit Card Authorization

THIS FORM, ONCE COMPLETED, IS FILED IN A HIPAA compliant secured server with ACCESS LIMITED TO ONLY THE PRACTICE MANAGER

Financial Policy:

We accept most insurance. If we are not on a specific insurance panel and considered out of network, you will be financially responsible for the visit. Payment is due at the time of service. We accept any major credit card and personal checks. NO CASH ACCEPTED.

No Show Fees Policy **Psychotherapy** ***late cancellation less than 24 hours in advance/no show appointments: $60***

A block of time is reserved for your appointment. If you must cancel or change the appointment for any reason, please give us 24-hrs. of advanced notice. If you fail to give us the advanced notice to cancel your appointment, then we will charge the following amount: $60. If you need to change your appointment and cannot provide 24 hours' notice, the $60 fee may be waived if we are able to schedule you into an open appointment slot within the same day of the originally scheduled appointment. Depression, Anxiety and Wellness Center reserves the right to charge the $60 fee .If such short notice changes happen on a regular basis (more than 3 times per 120 days) Please be advised that if you miss or no show, to more than 3 appointments in less than 120 days, then we reserve the right to refuse providing service at our clinic and will encourage you to follow-up with a different provider in the community. Upon termination of therapy the clinician will assist the client in finding other services or another therapist, when necessary. Closure is an important part of the therapeutic relationship for both the patient and the clinician. For this reason, we encourage a termination appointment for all patients that are ending individual therapy. Medicaid does not allow clients with Medicaid to be billed for a late cancel/no-show fee. Repeated cancellations of less than 24 hours in advance and no show missed appointments more than three in 120-day period will result in a loss of future appointment privileges.

Credit Card Policy:

Your credit card will be stored in our HIPPA compliant secured servers and will be used to charge your account towards any pending payments including but not limited to Co-pays, Co-insurances, Office visits, No- show fees, late cancellation fees and denied claims.

By signing this consent form, you agree to give Depression, Anxiety and Wellness Center the permission to charge your credit card remotely for any outstanding payments.

Client Name	Client Date of Birth
Credit Card Number	
Expire Date	***CVV Code (Front numbers for AMEX)***
Name as it appears on Card	
Billing address associated with the credit card	State and Zip
Cardholders Signature	Date

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