**Providence Psychotherapy Telemental Health Consent Form**

I have chosen to use Telemental Health (video sessions) for therapy sessions. I agree to and understand the following:

Providence Psychotherapy uses Doxy.me which is a HIPPA compliant Telemental Health format.

My therapist has completed training in Ethics on the use of Telemental Health.

Use Chrome or Firefox browsers for connectivity.

To sign into a session visit URL <https://doxy.me/providencepsychotherapy>.

.

Email, text and other means of communication are not HIPPA compliant means of communication but I agree to use those to facilitate initial paperwork exchange and schedule/reschedule appointments or relay other necessary information with my therapist.

Connectivity issues may occur during sessions. If this happens we will continue to try to establish connectivity or reschedule the session if needed. If connectivity is disrupted and cannot be reestablished text 478-396-8388 to speak to your therapist about how to proceed. If connectivity cannot be reestablished you are still responsible for the full fee of the session. Insurance will only pay for the time connection was maintained. If you schedule time you are responsible for the full fee of service. Most client’s needs work well with Telemental health. If not deemed clinically advisable your therapist may choose to cease using a video format for future sessions.

The same consent applies for Telemental health therapy sessions as was initially signed to begin therapy sessions with Providence Psychotherapy.

Payments will be made using a credit card on file agreement and processed by my therapist.

Credit Card On File Agreement for Co-pays or Payment of Therapy Services for Telemental Health Therapy Sessions

Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exp Date \_\_\_\_\_\_\_\_\_ CVV 3 digit code \_\_\_\_\_\_\_\_\_\_Zip code \_\_\_\_\_\_\_\_\_\_\_\_

Signature Authorization:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand and agree to the information on this form. I consent to participate in telemental health with Providence Psychotherapy. Sessions cannot begin until I email [pattiamelia@yahoo.com](mailto:pattiamelia@yahoo.com) or text this signed form.

Client Name (s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_