Therapy Solutions
TAKE YOUR LIFE BACK.

TELEHEALTH INFORMED CONSENT

Office Use Only
Client ID #______________
Staff Initials______________

I, ____, agree to participate in telehealth services with Therapy Solutions. I will be receiving mental health and/or physical, occupational, or speech therapy services through interactive videoconferencing and/or phone calls. I understand that my therapist will not be physically in the same room with me.

I understand that although Therapy Solutions makes every effort to protect my privacy by using a secure HIPAA-compliant server and platform and a secure phone line, they cannot guarantee the security of any information I transmit to them over the internet or phone. I understand there are risks and consequences in using telehealth services. The risks include, but are not limited to, the possibility that the transmission of sessions could be disrupted or distorted by technical failures. In case of technical failures, my therapist will make every effort to reconnect with me.

I have been notified that if my therapist believes I would be better served by another form of therapy services (e.g., face-to-face services), I will be referred to a therapist who can provide such services. I understand that my participation in this is voluntary, and I may decide to terminate my treatment at any time. I understand that there will be no recordings of my therapy sessions. I agree to not record my own therapy sessions without my therapist's knowledge or permission. I understand that the telehealth session will be billed to my insurance, WSI, auto-insurance, my provided EAP, or will be billed as self-pay, just like any other face-to-face session.

I understand that if I have a copay or self-pay for my telehealth sessions, it will automatically be charged to the card I have on file.

I give my consent to receive mental health, physical, occupational, or speech services through the telehealth system. I also understand that the services I receive will become part of my record at Therapy Solutions, and I understand my records will also be kept in Therapy Solutions Electronic Medical Records system.

Email Address: *(For Sessions)* ____

Signature of Client: ____ **Date:** _______________________

Signature of Parent/Legal Guardian/Representative: __________________________________ **Date:** _______________________

Signature of Therapist: ____ **Date:** _______________________

CREDIT CARD AUTHORIZATION

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Card Type: ☐ **MasterCard** ☐ **VISA** ☐ **Discover** ☐ **AMEX** ☐ **Other**____

Cardholder Name (as shown on card): ____

Card Number: ____

Expiration Date (mm/yy): _______ /________ **Cardholder ZIP Code (from credit card billing address):** ___________________

I, ________________________________, hereby authorize___________________________________ to charge my credit card for any copays or self-pay charges for my telehealth sessions. I am authorized to use this card and agree to not dispute the transactions, as long as they match the terms. I understand that this authorization allows for regularly scheduled charges to my credit card for the purpose of payment. A receipt will be provided for each payment, and the charge will appear on my credit card statement.

Charges will typically be processed within 1-3 business days after each telehealth session. Customers will receive advance notice for changes to the date or amount, but generally not for regular session charges. The authorization remains effective until canceled in writing, with notification required at least 15 days before the next billing date.

Customer Signature: ____ **Date:** _______________________