Telehealth document

Telehealth telemedicine:
I hereby consent to engaging in a telehealth/telemedicine program with **Anne Burkart, MAC, LPC, LCPC, LCAC** as part of my psychotherapy and online counseling. I understand that telehealth/telemedicine includes the practice of healthcare delivery, assessment, diagnosis, consultation, treatment, transfer of medical information, and psychoeducation using interactive audio, video, or communications. I understand that, with my signed consent, telehealth may also involve the communication of my mental health information to other healthcare practitioners.

Technology: I understand the minimum requirements for this service are a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. I also understand that in case of technology failure my counselor will call me at _____ (please list preferred number here).

Financial obligations: Fees associated with telehealth appointments are payable by credit or debit card only. If fees are associated with my Telehealth services, I agreed to have my debit or credit card information on file. My card will be billed the same day as my scheduled telehealth appointment. If my card is declined, my appointment will be canceled. If I do not show for my scheduled appointment, I will be charged in accordance with the cancellation policy. _____ (Client initial)

Clients using insurance: I authorize insurance benefits to be paid directly to Anne Burkart Counseling LLC and she may release any information required for processing my claims.

Self-pay clients: I am aware of the fees associated with telehealth appointments and agreed to pay at the time of my appointment. I understand that I am responsible for canceled telehealth appointments in accordance with the cancellation policy and as documented by my signature on this form.

Scheduling: I understand that scheduling is conducted through the front office (816-753-7071) or through your patient portal and is based on my provider's normal clinical hours. Telehealth appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the local county crisis line or by dialing 988. If a crisis occurs during session, I understand my counselor will contact local crisis response.

Video/audio recording: Recording of sessions is prohibited.

Confidentiality: The laws that protect the confidentiality of my medical information also apply to Tele health. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality. These include, but are not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim or towards myself; and where I make my mental or emotional state an issue in a legal proceeding. The Telehealth platforms are HIPPA compliant to protect my privacy and confidentiality. This is further explained in the mental health informed consent above.

I understand that I have the following rights with respect to Telehealth:

- I have the right to withdraw my consent at any time.
- I understand that there are risks and consequences associated with telemedicine. I understand the telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my counselor therapist believes I would be better served by another form of therapy services such as face-to-face services, I will be referred to a counselor/therapist who can provide such services in my geographic area.
- I understand that I may benefit from telehealth sessions but that results cannot be guaranteed or assured.
- I understand that I have the right to assess my mental health information and copies of medical records in accordance with state law.

I have read and understand the information provided above. I will discuss it with my counselor/therapist if I have any other questions. My signature below indicates my informed and willful consent to treatment using this platform.

Consent for treatment, financial responsibility and release of information:
By signing or typing my name on this document I am attesting that I have received, read, fully understand and consent to the disclosures, terms, and conditions above, contained in the individual provider information and the fee schedule, and have been given the opportunity to ask questions. By signing or typing my name in this document, I am consenting to participation in services provided by the provider named below. Healthcare Operations: We may need to use information about you to review our treatment procedures and business activity and to manage your care or related services. Information may be used for coordinating care or related services. It could include consultants and potential referral sources, certification, compliance and licensing activities.

I agree to be financially responsible for canceled appointments in accordance with the cancellation policy as documented by typing my name on this informed consent. I authorize insurance benefits to be paid directly to Anne Burkart Counseling LLC and she may release any information to my insurance provider required for processing my claims.

_____	_____	_____
Client name (please print)	Signature	Date
_____	_____	_____
Legal guardian name (if applicable)	Signature	Date