Hendricks Therapy
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Current Date: Patient: Date of Birth:

Consent for Treatment and Acknowlegements for Teletherapy Services

By signing below, I represent the following to be true:

1. Consent for Remote/Teletherapy Care Services: I authorize consent for my treatment at Hendricks Therapy via remote services, aka Teletherapy.

2. I acknowledge and confirm that:

- I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.
- I will be participating with my provider(s) remotely, via a secure internet-based platform, and will not be face-to-face in an office setting.
- I will treat Teletherapy services the same as a face-to-face therapy appointment, including all participants:
    - Dressing appropriately,
    - Checking in and being available by or before my scheduled start-time,
    - Planning to participate for the complete scheduled time of the session.
- I am responsible for ensuring that I am able to connect via a device that meets the minimum requirements, including a fully functioning webcam, microphone, speakers, and a reliable internet connection, and I understand how to connect to my session before it begins.
- I am responsible for ensuring and maintaining the privacy/confidentiality of my environment during the session, including minimizing or removing any distractions or disruptions. I understand that my provider(s) will maintain a confidential environment on his/her end, but cannot control the privacy/confidentiality of my environment.
- Hendricks Therapy is not designated as a crisis unit, and teletherapy services are not intended for patients in an emergent crisis.
    - In situations where my provider(s) determines there is an emergency during the session, the provider(s) will attempt to maintain communication with me while arranging for emergency services to my location as needed. It is my responsibility to utilize emergency services, and I assume this risk when using teletherapy/distance counseling.
- My provider(s) may send emergency services or “wellness checks” to my location at his or her discretion, in the case of a disconnected/terminated session wherein I or someone in my presence is deemed unsafe.
- Teletherapy appointments will be treated the same as face-to-face appointments, including but not limited to acknowledging that:
    - I am responsible for the payment and/or co-payment that is due at the time of service,
    - I may be charged for late-canceled (less than 24 hours' notice) or missed appointments (including logging in late or poor connections on my end).
    - Scheduling and payments will occur through Hendricks Therapy staff during normal business hours. I agree to contact Hendricks Therapy within 2 business days if I have not been contacted by a member of Hendricks Therapy staff.
- Charges are based on the provider's professional determination of services provided to you and may vary from face-to-face charges.
    - My insurance(s), if applicable, will be billed for my teletherapy services,
    - I am responsible for all costs denied or not covered by my insurance, including copayments, co-insurances, deductibles, and/or non-billable services/charges.
    - Charges for disrupted sessions, including disruptions out of my control, are at the sole discretion of my provider(s).

3. Consent for Family Members participating in Teletherapy:

- I understand that Teletherapy is designed for families, and I am responsible for ensuring that all participating members are aware of and follow the acknowledgements listed above, as well as any further instructions or requests from my provider(s). This includes but is not limited to those individuals named below.
- Other family members who are expected to regularly participate in sessions, and with whom I consent to the sharing of my treatment and related information, are (this includes parents/step-parents, siblings, other individuals living in the home(s) where sessions will most likely take place):

Name, Age, AND Relation	Name, Age, AND Relation
Name, Age, AND Relation	Name, Age, AND Relation
Name, Age, AND Relation	Name, Age, AND Relation

Patient / Legal Respresentative Signature

(If other than Patient) Print Name and Relationship to Patient