Waterstone Counseling Centers, LLC

Addiction Medicine & Psychotherapy Services

INFORMED CONSENT TO TELEHEALTH

Telehealth allows my clinician to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in medical treatment and/or psychotherapy via a HIPPA compliant web platform (hereinafter referred to as Telehealth). 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 HIPPA for in-person medical treatment and/or psychotherapy. Any information disclosed by me during the course of my treatment, therefore, is generally confidential.

I understand that in order to participate in Telehealth I must disclose my physical/ geographical address at the time of the service. I understand that Telehealth therapy sessions should be treated with the same respect, attention and confidentiality as in-person office visits. I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I understand there is a possibility that the telehealth sessions could be disrupted or distorted by technical failures or could be interrupted.

I understand that Telehealth treatment is different from in-person treatment and only made permissible by my treatment team the following instances:

- Medical documentation stating I cannot attend services on site. Must provide note from primary provider with to and from dates of quarantine.
- Allowed 1 telehealth session per quarter for cases of transportation, childcare, work or undocumented illness

17 Wall Street, Madison, CT 06443
p:203-245-0412 f: 203-245-0572
317 Long Hill Road, Groton, CT 06340
P: 959-201-6639 F: 203-245-0572

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I have read and understand the information provided above. I understand that I can withdraw my consent to Telehealth communications by providing written notification to my provider(s). My signature below indicates that I have read this Agreement and agree to its terms. I understand that in order to participate in Telehealth I will need to provide WCC with a credit card which will be kept on file to be used as a form of payment for fees incurred for co- pays, co-insurance, deductibles, late cancelations, missed appointments, returned checks, or past due account balances.

Credit Card # _____

Name on Card _____

Zip code for Card _____

Exp Date: _____

Sec Code on back of card: _____

Client Name (print): _____

Signature:_____ Date:_____

*If client is under age 18 a legal guardian's signature is required

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