Counseling Centers
Addiction Medicine & Psychotherapy
Tel (203)245-0412 Fax (203)612-9030
LOCATIONS
Madison · Groton · New Haven

Client/Patient Telehealth Agreement with Waterstone Counseling Centers

PLEASE READ THOROUGHLY AND SIGN.

Telehealth allows my doctor and/or therapist 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 that there is a possibility that the telehealth session could be overheard by someone in my environment and acknowledge that Waterstone has no control over possible confidentiality breaches from my location.

● 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:

1. Medical documentation stating I cannot attend services on site.
2. Allowed 1 telehealth session per quarter for cases of transportation, childcare, work or undocumented illness. Any additional sessions are on a case-by-case basis.

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 Waterstone 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 cancellations, 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: _____

Name(print):_____ Signature:_____

Date:_____

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