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**Eugenia Foster MA, LMFT**

**Chaperone Counseling Services**

**3415 S. Sepulveda Blvd. Suite 1145 Los Angeles 90034**

**562-284-7735**

**Disclosure Statement**

I am a Licensed Marriage and Family Therapist with almost 20 years of professional counseling experience. I earned my Master's degree at National University and my BA degree at Cal State Northridge. I obtained my license through the state of California in 2010 (LMFT-49221). Throughout my career I have provided services for families adolescents, teens, and adults. My experience and training focuses on improving relationships and daily functioning.

**Fees:** The fee for counseling is $195 per 46-60 minute in-person session for individuals and $225 for couples. Virtual sessions also available. Pricing will be discussed prior to onset of treatment. Services are an out of pocket or co-pay cost for Kaiser Patients and payment is due at onset of each session. Other insurance options may be offered. Checks can be made payable to Chaperone Counseling Services. A $30 fee will be charged for returned checks. Unpaid balances incur the maximum finance charge allowed by law after 30 days. Outstanding balances may be sent to a collection agency. Convenience fees from $1 -$ 10 are assessed per credit card transaction.

**Missed Appointments:** Clients are asked to follow the cancellation policy. Appointments may be cancelled and/or rescheduled within 48hrs without penalty. Clients who do not follow the 48 hr. cancelation policy will be charged the full fee for the session. (Kaiser does not reimburse for missed or cancelled appointments). Missed and cancelled appointments outside of the cancelation policy will be charged by credit card. If you are late, the session will stop at the regular ending time and you will be required to pay for the entire session. Tele-therapy is not offered in lieu of cancelation policy.

**Contacting Therapist:**Clients with needs occurring outside of scheduled appointment times or outside of business hours will be directed to Therapist's voice mail or email. Calls and emails will be returned the following business day or sooner at Therapist's discretion. Clients experiencing an emergency are directed to call 911 and/or go to the nearest hospital.

**State Mandated Disclosure:**Clients have a right to confidentiality. Exceptions to confidentiality are in cases of Suicidal or Homicidal ideation with intent and plan to hurt self and/or others. Therapist is also mandated to report elder and child abuse. Therapist follows cede of ethics governed by the State of California and is currently a member of CAMFT, professional association for California Marriage and Family Therapists.

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**Termination of Treatment:** You may terminate treatment at any time without moral, legal, or financial obligation beyond payment of services already rendered. If you fail to schedule a future appointment or fail to keep or cancel a scheduled appointment and do not contact me within 30 days of the date of last contact, it will be understood that you have terminated treatment. I shall have no further obligation to you once treatment has been terminated.

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Client Signature Date

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Client Signature Date

**HlPAA COMPLIANCE NOTlCE OF PRIVACY PRACTICES**

**This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. This Information will include Protected Health lnformation (PHI). as that term is defined in privacy regulation issued by  the United State Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act Of 1996 ("HIPAA") and, as applicable, California Health and Safety Code (Division 110) "The Health Insurance Portability and Accountability Implementation Act of 2001 "§130300 -130317, and California Civil Code 56, -56.37. Please review it carefully.**

We respect your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example.your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

**Protected Health Information:**

*Protected health information* means individually identifiable health information:

• Transmitted by electronic media;

• Maintained in any medium described in the definition of electronic media; or

• Transmitted or maintained in any other form or medium.

**Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health**

**Operations**

**For treatment**

• Information obtained by a nurse, physician, clinical psychologist, MSW, therapist, or other member of our healthcare team will be recorded in your medical record and used to help decide what care may be right for you.

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• We may also provide information to others providing you care. This will help them stay informed about yourcare.

**For payment:**

• In California State, written patient permission is required to use or disclose PHl for payment purposes, includingto your health insurance plan. We will have you sign another form Assignment of Benefits or similar form for thispurpose (Cal. Civ. Code § 56.10 -56.16). Health plans need information from us about your medical care.Information provided to health plans may include your diagnosis, procedures

**For health care operations:**

• We use your medical records to assess quality and improve services.

• We may use and disclose medical records to review the qualifications and performance of our health care

providers and to train our staff.

• We may contact you to remind you about appointments and give you information about treatment alternatives orother health-related benefits and services.

• We may use and disclose your information to conduct or arrange for services, including:

medical quality review by your health plan;accounting, legal, risk management, and insurance services;

audit functions, including fraud and abuse detection and compliance programs.

(\_\_\_\_\_\_\_\_\_ Patient Initials)

**Your Health Information Right**

The health and billing records we create, and store are the property ofÂ health care provider. The protected health information in it, however, generally belongs to you.You have a right to;

• Receive, read, and ask questions about this Notice;

• Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required

to grant the request. But we will comply with any request granted;

• Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected HealthInformation ("Notice");

• Request that you be allowed to see and get a copy of your protected health information. You may make this requestin writing. We have a form available for this type of request.

• Have us review a denial of access to your health information -except in certain circumstances;

• Ask us to change your health information. You may give us this request in writing. You may write a statement ofdisagreement if your request is denied. It will be stored in your medical record and included with any release ofyour records.

• When you request, we will give you a list of disclosures of your health information. The List will not includedisclosures to third party partners.You may receive this information without charge once every 12 months. We willnotify you of the cost involved if you request this information more than once in 12 months.

• Ask that your health information be given to you by another means or at another location. Please sign, date, andgive us your request in writing.

• Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocationdoes not affect information that has already been released. It also does not affect any action taken before we haveit. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact our Privacy Officer:

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**Psychotherapy Notes:**

Notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. *Psychotherapy Notes* excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis. functional status, the treatment plan, symptoms, prognosis, and progress to date. An authorization to use or disclose psychotherapy notes required except if used by the originator of the notes for treatment to a person or persons reasonably able to prevent or lessen the threat (including the target of the threat), if the originator believes in good faith that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, if the notes are to be used in the course of training students. trainees or practitioners in mental health; to defend a legal action on or any other legal proceeding brought forth by the patent; when used by a medical examiner or coroner; for health oversight activities of the originator; or when required by law.

(\_\_\_\_\_\_\_\_\_ Patient Initials)

**Our Responsibilities**

**We are required to:**

• Keep your protected health information private;

• Give you this Notice;

• Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes.we will update this Notice, You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office or medical records department to pick one up.

**To Ask for Help or Complain**

The California Bond of Psychology regulates the practice of Psychology in the state of California. Concerns or complaintsregarding the practice of psychotherapy may be directed to the California Board of psychology.

**The contact information is :**

2005 Evergreen Street Suite 1400, Sacramento. CA 95815-3831 or bopmail@dca.gov

Toll Free Number: 1-866-503-3221

You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain we will not retaliate against you.

**Other Disclosures and Uses of Protected Health Information**

**Notification of Family and Others:**

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• Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. This would be limited to your name and general health condition

(for example, “critical,” ”poor,” "fair," “good,” or similar statements). In addition.we may disclose health information about you to assist in disaster relief efforts.

You have the right to object to this use or disclosure of your information. If you object we will not use or disclose it.

(\_\_\_\_\_\_\_\_\_ Patient Initials)

We may use and disclose your protected health information without your authorization as follows:

• **With Medical Researchers**-if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.

• To the **Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.

• **To Comply with Workers' Compensation Laws** -if you make a workers' compensation claim.

• **For Public Health and Safety purposes as AIlowed or Required by Law:**

• to prevent or reduce a serious, immediate threat to the health or safety of a person or the public.

• to public health or legal authorities

• to protect public health and safety

• to prevent or control disease, injury, or disability

• to report vital statistics such as births or deaths.

• **To Report Suspected Abuse or Neglect** to public authorities.

• **To Correctional Institutions** if you are in jail or prison.as necessary for your health and the health and safety of others.

• **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a.crime.

• **For Health and Safety Oversight Activities**. For example, we may share health information with the Department of Health.

• **For Disaster Relief Purposes**. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.

• **For Work-Related Conditions That Could Affect Employee Health**. For example an employer may ask us to assess health risks on a job site.

• **To the Military Authorities Of U.S. and Foreign Military Personnel.** For example, the law may require us to provide information necessary to a military mission.

• **In the Course Of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order

• **For Specialized Government Functions.** For example, we may share information for national Security purposes.

• **To Coroners, Medical Examiners, Funeral Directors**, We may disclose PHl to a coroner or medical examiner to identify a deceased person and determine the cause of death. In addition, we may disclose PHI to funeral directors, as authorized by law, so that they may carry out their jobs.

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• **Organ and Tissue Donations**, If you are an organ donor, we may use or disclose PHI to organizations that help procure, locate and transplant organs in order to facilitate an organ, eye or tissue donation and transplantation.

• **Incidental Disclosures.** We may use or disclose PHI incident to a use or disclosure permitted by the HIPAA Privacy Rule so long as we have reasonably safeguarded against such incidental uses and disclosures and have limited them to the minimum necessary information.

• **Limited Data Set Disclosures**, We may use or disclose a limited data set (PHI that has certain identifying information removed) for purposes of research public health, or healthcare operations. This information may only be disclosed for research public health and health care operations purposes. The person receiving the information must sign an agreement to protect the information.

(\_\_\_\_\_\_\_\_\_ Patient Initials)

**Special Authorizations**

Certain federal and state laws that provide special protections for certain kinds of personal health information call for specific authorizations from you to use or disclose information. When your personal health information falls under these special protections, we will contact you to secure the required authorizations to comply with federal and state haws such

as:

• Confidentiality of Medical lnformation (CA Civ. Code 56 -56.37)

• Sexually Transmitted Disease (HSC, Division 105,120500 -120750)

• Registration of Narcotic, Alcohol, and Other Drug Abuse Programs (HSC, Division 10.5,11842 -11845.5)

• Adolescent Health (HSC, Division 106.124175 -124260)

• Communicable Disease Prevention and Control (HSC, Division l05,120100 -122450)

• Confidentiality of Alcohol and Drug Abuse Patients (42 CFR Part 2)

If we need your health information for any other reason that has not been described in this notice, we will ask for your written authorization before using or disclosing any identifiable health information about you. Most important if you choose to sign an authorization to disclose information, you can revoke that authorization at a later time to stop any future

use and disclosure.

**Other Uses and Disclosures Of Protected Health Information**

• Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

**Effective Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,20**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND FINANCIAL

AGREEMENT (Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and California Health and Safety Code (Division 110) "The Health Insurance Portability and Accountability Implementation Act of 2001" § 130300 + 130317, and California Civil Code 56 -56.37.

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**Eugenia Foste**r keeps a record of the health care service we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes compels us to do so. You may see your record or get more information about it by contacting our Privacy Offer. Written requests should be made to the Privacy Officer at the following address:

Eugenia Foster MA, LMFT

3415 S. Sepulveda Blvd. Suite

1145 Los Angeles 90034

**562-284-7735**

**Our Notice Of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

(\_\_\_\_\_\_\_\_\_ Patient Initials)

**PATIENT ACKNOWLEDGEMENT:**

**BY MY SIGNATURE BELOW I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.**

**VERIFICATION 0F MEDICAL CONSENT:** I, the undersigned, hereby agree and consent to the plan of care proposed to me by the Covered Entity. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse medical care. I will ask for any information I want to have about my medical care and will make my wishes known to the Covered Entity and/or its staff. The Covered Entity shall not be liable for the acts or omissions of others.

**AUTHORIZATION TO RELEASE INFORMATION - IF APPLICABLE:** I the undersigned, hereby authorize the Covered Entity and/or its staff, to the extent required to assure payment, to disclose any diagnosis and pertinent medical information to a designated person, corporation, governmental agency or third party payer which is liable to the Covered

Entity for the Covered Entity’s charges or who may be responsible determining the necessity, appropriateness.or amount related to the Covered Entity's treatment or charges, including medical service companies, insurance companies, workmen's compensation carriers, Social Security Administration, intermediaries, and the State Department of Health and

Human Services when the patient is a Medicaid or Medicare recipient. This consent shall expire upon final payment relative to my care.

**FINANCIAL AGREEMENT:**

**PRIVATE PAY:** I, the undersigned. hereby agree. whether signing as agent or as a patient, to be financially responsible to the Covered Entity for all charges not paid by insurance. I understand this amount is due at the beginning of the session.

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**INSURANCE COVERAGE - IF APPLICABLE:** I certify that the information given to me in applying for payment under government or private insurance is correct. I hereby assign payment directly to the Covered Entity for benefits otherwise payable to me. Any portion of changes not paid by the insurance company will be billed to me and is then due and payable within thirty (30) days Of invoice. I understand

the Covered Entity will verify my insurance coverage but that this does not guarantee payment by the insurance company and I will be responsible for all non-covered charges. I understand that it is my responsibility to determine the coverage limits of my insurance.

I understand a minimum monthly fee of 1% (annual rate of 12%) may be changed for late payment on all balances not covered by insurance. This is in addition to a change for reasonable attorney fees, court costs, and collection agency

expenses incurred to collect the amount due.

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Patient or legally authorized individual signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name if signed on behalf of the patient Relationship

(parent, legal guardian, personal representative)

(\_\_\_\_\_\_\_\_\_ Patient Initials)

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**Eugenia Foster MA, LMFT**

*Chaperone Counseling Services*

3415 S. Sepulveda Blvd. Suite 1145 Los Angeles 90034

**562-284-7735**

**CREDIT CARD PAYMENT AUTHORIZATION FORM**

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Sign and complete this form to authorize Chaperone Counseling Services, to debit your credit card as listed below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this form, you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for therapeutic treatment fees accrued while in treatment with your therapist and does not provide authorization for any additional unrelated debits or credits to your account. Credit cards may be run in the event that you forget to bring cash, check or a valid credit card to your session. Credit cards will also be debited in the event that you fail to give adequate notice by phone or email of missing an appointment. No more than two consecutive missed appointments will be billed. A receipt of credit card processing will be sent to the email provided below upon request.

**Please complete the information below:**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(full name printed) authorize Chaperone Counseling Services, to charge my credit card account indicated below (your card may also be copied for our records). Fees accrued for missed appointments or failure to provide payment at the time of service will be processed via credit card at the rate of $195 per 45-60 minute session for individual and $210 per couple or family session including convenience fees.

Billing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Account type [ ] Visa [ ] Mastercard [ ] AMEX [ ] Discover

Cardholder Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CVV2(digits on back)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, authorize Chaperone Counseling Services, to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the services described above, for the amounts indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ONLINE THERAPY INFORMED CONSENT**

**EUGENIA FOSTER**

**chapronedate@gmail.com**

**562-284-7735**

[**https://doxy.me/Chapertme**](https://doxy.me/Chapertme)

I hereby consent to engaging in telemedicine (also referred to as online therapy) with Eugenia Foster, LMFT for psychotherapy services. I understand that "telemedicine" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to health care practitioners located in California or outside of California.

**I understand that I have the following rights with respect to telemedicine:**

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment; nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

The laws that protect the confidentiality of my medical information also apply to telemedicine. 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, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim or myself; and where I make my mental or emotional state an issue in a legal proceeding. This information is detailed in the Notice of Privacy Practices that I received. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

I accept that telemedicine does not provide emergency services. During our first session, Eugenia Foster, LMFT and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24-hour hotline support.

I understand that I have a right to access my medical information and copies of medical records in accordance with California and California law.

I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured. Advantages of telemedicine include, but are not limited to: increased access to a broader range or providers, elimination of transportation concerns such as access and cost, easier access for clients whose concerns around travel/anxiety/interaction would have prevented their access to services, reduced risk for medically fragile clients, increased comfort and familiarity for clients in their own environments.

**Telemedicine sessions will be held with the use of** [**https://doxv.me**](https://doxv.me)**. :**

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**ONLINE THERAPY INFORMED CONSENT**

**EUGENIA FOSTER**

**chapronedate@gmail.com**

**562-284-7735**

[**https://doxy.me/Chapertme**](https://doxy.me/Chapertme)

I understand that telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my

efforts and the efforts of my psychotherapist, my condition may not be improved, and in some cases, may even get worse.

I understand that there are technological risks specific to telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I

understand that my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "auto-remember" usernames and passwords, or use my work computer for personal communications; and that I am solely responsible for securing this end of our interaction.

**I understand that I am responsible for:**

( 1 ) Providing the necessary computer, telecommunications equipment for my telemedicine,

(2) Personal security and or protection on my computer,

(3) Location with sufficient lighting and privacy that is free from distractions or intrusions,

(4) Reliable and secure high-speed internet connection.

(5) Backup form of communication (handy and on record) if the internet connection fails.

After we connect I will help my therapist complete a check-in to ascertain the immediate

suitability of telemedicine by verifying my name, location, whether I am in a situation conducive

to a private, uninterrupted session, and my readiness to proceed. I will maintain current local

emergency contact information with my therapist.

**I have read and understand the information provided above.**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telemedicine sessions will be held with the use of** [**https://doxv.me**](https://doxv.me)**. :**

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