Living Well
COUNSELING SERVICES, LLC

6117 Monona Dr. #1
Madison, Wisconsin 53716
Phone 608-223-1506
Fax 608-223-1745
www.lwcounseling.com

Authorization for TeleMentalHealth(TMH) - Video or Phone Sessions

Patient Name: _____ DOB: _____

1. I understand that my healthcare provider may be offering to engage in telemedicine during a local emergency if directed by the government or if my therapist or I feel more comfortable with that method of contact.
2. My health care provider has explained to me how the video conferencing technology will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with another individual for billing purposes, same as an in-person visit.
5. In an emergent consultation, the therapist's responsibility will conclude upon the termination of the video conference connection.
6. I understand that billing will occur from my practitioner and some insurance companies, especially EAPs, may deny video or phone sessions and I am still responsible for the fee agreed upon with my therapist.
7. My questions about video/phone sessions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

1. That I have read or had this form read and/or had this form explained to me.
2. That I fully understand its contents including the risks and benefits of the procedure(s).
3. That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____

Patient's/parent/guardian signature Date

This signed form shall be in effect for one year from the date of signing unless revoked in writing.