Please review, complete and sign all 3 (three) Telehealth forms below. Once completed, please scan, or take a photo, then email the forms to judith@therapy4mbs.com.

Thank you.

I look forward to guiding you along your journey!

Many blessings,
Judith

Judith N. Snyder, LPC
Licensed Professional Counselor
judith@therapy4mbs.com

Client Name: ____________________________ Date: _________

1. I understand that my therapist will be using telehealth consultation and that there are differences between this type of consultation and that of a direct client/therapist consultation.

2. I understand that there are potential risks to this consultation, including interruptions, unauthorized access by others within my home, and technical difficulties, and I take full responsibility in making sure my environment is completely confidential and free from interference. I also understand that my therapist or I can discontinue the telehealth consultation if it is felt that the connection is not adequate for the situation.

3. I understand that my therapist information may be shared with other individuals for billing purposes.

4. I have had a direct conversation with my therapist, and I have had the opportunity to ask questions regarding this type of therapy. My questions have been answered and the risks, benefits and any practical alternatives have been discussed in a way that I understand.

   By signing this form, I certify:

   - I have read this form and fully understand its contents including the risks and benefits of telehealth services
   - I have been given ample opportunity to ask questions and my questions have been answered satisfactorily.

My signature below indicates that I understand and agree to the contents of this form.

__________________________ __________________________ _______
Name of Client (Print) Signature Date

__________________________ __________________________ _______
Name of Clinician (Print) Signature Date

EMERGENCY PROCEDURES SPECIFIC TO TELEHEALTH SERVICES

If you have a mental health emergency, please do not wait for communication back from me, but do one or more of the following:

- Go to the closest emergency room
- Call 911
- Call the crisis center at which you reside.
    - Lehigh County Crisis 610-282-3127
    - Northampton County Crisis 610-252-9060
    - Carbon County Crisis (800) 338-6467
- Call National Suicide Prevention Lifeline at (800) 273-8255

There are additional procedures that need to be in place specific to Telehealth services. These procedures are for your safety in case of an emergency and are as follows:

If you are having suicidal or homicidal thoughts or symptoms, telehealth services are not appropriate, and I may determine that you need a higher level of care. I require an Emergency Contact Person (ECP) who I may contact on your behalf if needed in a life threatening emergency. Please enter this person's name and contact information below. In the event of an emergency, please verify that your ECP is willing and able to go to your location. Additionally, if you, or your ECP, or I determine necessary, the ECP agrees to take you to the hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

Please list your ECP here:

Name: ______________________________________

Phone Number: ____________________________________

You agree to inform me of the address where you are at the beginning of each session. You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go in the event of a mental health emergency.

Please list this hospital and contact number here:

Hospital: ____

Phone Number: _______________________________________

You agree to inform me of the nearest police department to your primary location that you prefer to go to in the event of an emergency.

Please list this police department and contact number below:

Police Department: _____________________________________

Phone Number: ____

My signature below indicates that I understand and agree to the contents of this form.

________________________	______________________	_________
Name of Client (Print)	Signature	Date
________________________	______________________	_________
Name of Clinician (Print)	Signature	Date

TELEHEALTH SESSIONS FINANCIAL AGREEMENT

I, ________________________________ acknowledge that I have been informed that the telehealth sessions I requested for myself may not be covered by my insurance company, and I have called my insurance company to confirm coverage of telehealth service. In the event that my services are not covered, I am assuming full monetary responsibility for the sessions which rates will be accommodated to my insurance contractual rate of an in-person session.

I understand that Telehealth sessions may be cancelled or rescheduled until 48 hours before the scheduled appointment. After 48 hours, my therapist will do her best to reschedule the session, though this option may not always be possible. I understand that if the session cannot be rescheduled, refunds will not be available.

I, or my financially responsible Party, will make payment prior to my appointment.

PATIENT AUTHORIZATION

I have read and agree to the above statements.

I will send payment prior to my appointment. I confirm calling my insurance plan and verifying coverage is part of my plan.

My signature below certifies that I have read and agree to all policies, authorizations and payment requirements. I understand that the stated policies apply to all telehealth services rendered.

Client Name (print): ____________________________ DOB: _____________

Patient Signature: ______________________________ Date: _______________

Responsible Party Name: _____________________________

Signature: ______________________________ Date: __________________