Integrated Care Concepts & Consultation
New Jersey's Premier Mind/Body Service Provider

J. Larry Thompson
LCSW, Founder

Seth A. Arkush
MBA, LCSW, Partner

Consent for Payment of Services

This Agreement for Telehealth Services ("Agreement") is a temporary execution of services effective as of_____, 20__("Effective Date") by and between Integrated Care Concepts & Consultation, and,_____("Clinician"), and _____("Client Name/Guardian if under age 18").

1. I/the client acknowledge the telemedicine program's no-show policy which states that I/the client/guardian will be discharged from the telemedicine program if I/the client/guardian no-show for appointments, without prior contact to Integrated Care Concepts and Consultation/clinician/practitioner/psychiatrist. I understand that no-showing will result in a full charge of services to my credit card on file. Initials: _____

2. I agree to this consent for payment of telehealth services and agree to have my credit card charged according to this policy for services.

Credit Card Type: _____
Credit Card Number: _____
Credit Card Code:_____Exp. Date: _____
Credit Card Name as it appears:

_____
_____
_____

Client/Guardian Name and Signature:

_____

_____

Date: _____

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Consent for Telehealth Treatment

This Agreement for Telehealth Services ("Agreement") is a temporary execution of services effective as of _____, 20__("Effective Date") by and between Integrated Care Concepts & Consultation, and,_____("Clinician"), and _____("Client Name/Guardian if under age 18").

1. I have been fully informed of my rights as a client of this agency, the extent and limits of confidentiality in therapy, and the goals associated with this telehealth therapy. As such, Telehealth is being defined as mental health service provided to clients over a remote HIPAA compliant technology platform. I request and consent to receive telehealth therapy from Integrated Care Concepts and Consultation, and from qualified personnel of this agency. Initials: _____

2. The type of service to be provided by via telehealth is: (Circle applicable services) Initials: _____
   Mental Health Counseling
   Psychiatry

3. I understand that this service is not the same as a direct patient/healthcare provider visit, because I/the patient will not be in the same room as the healthcare provider performing the service. I understand that parts of my/the patient's care and treatment which require physical tests or examinations may be conducted by providers and their staff at my/the patient's location under the direction of the telemedicine healthcare provider. Initials: _____

4. I understand the nature of this telehealth technology is resultant from the current coronavirus outbreak. I understand that there may be disruption in the session flow and form of this telehealth experience and session and I understand there is opportunity for me to ask questions and participate in this session. Initials:_____

5. I understand that there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. Although the use of telehealth technology affirms HIPAA compliance, I am aware that I, my clinician/practitioner/psychiatrist, can discontinue the telemedicine service if we believe that the videoconferencing connections are not adequate for the situation. Initials: _____

6. I understand and agree that the telemedicine session will not be audio or video recorded at any time by myself, by the clinician/practitioner/psychiatrist, nor Integrated Care Concepts and Consultation, nor the technology platform host. Initials: _____

7. I agree to permit my/the client's healthcare information to be shared with other individuals for

scheduling and billing. I agree to permit individuals other than my/the client's healthcare provider and the remote healthcare provider to be present during my/the patient's telemedicine service to operate the video equipment, if necessary. I further understand that I will be informed of their presence during the telemedicine services. I acknowledge that if safety concerns mandate additional persons to be present, then my or the guardian's permission may not be needed. Initials: _____

8. It is the responsibility of the telemedicine provider (clinician) to conclude the service upon termination of the videoconference connection, and it is the responsibility of the client/guardian, to close their session as well. Initials: _____

9. I /the client/guardian understand(s) that my insurance will be billed by for services. I/the client/guardian understand(s) that if my insurance does not cover this service that I will be billed directly. Initials: _____

10. I/ the client/guardian's consent to participate in this telemedicine service shall remain in effect for the duration of the specific service as identified above, or until I terminated under the termination clause listed below. Initials: _____

11. I /the client/guardian agree that there have been no guarantees or assurances made about the results of this service. Initials: _____

12. I /the client acknowledge the telemedicine program's no-show policy which states that I/the client/guardian will be discharged from the telemedicine program if I/the client/guardian no-show for appointments, without prior contact to Integrated Care Concepts and Consultation/clinician/practitioner/psychiatrist. I understand that no-showing will result in a full charge of services to my credit card on file. Initials: _____

13. I understand that the staff of this agency may not disclose information about my therapy to anyone outside this agency without my written consent, except as required by law to comply with a court order, to prevent suicide/self-harm or harm to others, or to stop or prevent abuse of a child, senior, or a disabled person. However, I also understand that my participation in treatment may require my written consent to allow staff of this agency to provide some information about my therapy to a referring agency and/or an insurance company or other payer, and that if this is the case, the form provided for my written consent for this disclosure will state what specific types of information will be disclosed. Initials: _____

14. I understand that my therapist will be working with me at this agency, in my home, in their home, or in other settings. I agree that when utilizing telehealth services, that I will do so in a room or environment that is safe, private, and confidential. Initials: _____

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15. TERM AND TERMINATION**.** This Agreement shall commence on the Effective Date and continue until terminated by either party. Initials: _____

15.1 Termination Without Cause. Either party may terminate the Agreement without cause upon thirty (30) days prior notice. Initials: _____

15.2 Termination With Cause. Either party may terminate the Agreement immediately. Initials: _____

16. I confirm that I have read and fully understand this telehealth consent for treatment form.

Client/Guardian Name and Signature:

_____

_____

Date: _____

Therapist Name and Signature:

_____

_____

Date: _____