Consent & Statement of Understanding: Telehealth Video Sessions

Client Information

Name: Date of Birth:

Home address: City / State / Zip:

Phone: (Work) Phone: (Home) Phone: (Cell)

I hereby authorize Clearhope Counseling Center and its associates to use Vsee.com, Google Meets, Doxy or Bluestream as a means for psychotherapy. These are HIPAA compliant platforms for telecommunication. I understand that we may use other HIPAA compliant telecommunication platforms not listed above. I further attest that since I have chosen this form of communication, I have been advised that it may not be covered by my insurance company and that I am responsible for any fees incurred during psychotherapy that incorporates telecommunication.

I understand that I may revoke this authorization at any time by giving written notice, except to the extent Clearhope Counseling Center has already taken action in reliance on it. I may specify the date, event, or condition on which this consent expires. If none is stated, and if no prior notice of revocation is received, this consent will expire one year after the date it was initiated.

(age 12 and older)

Client Full Name	Client Signature	Date
Parent/guardian of minor OR of legally disabled recipient Full Name	Parent/guardian of minor OR of legally disabled recipient Signature	Date

Witness Signature Date