Dr. Cheryl Outen, LPC
Telehealth Informed Consent

I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider, and hereby consent to Dr. Cheryl Outen, LPC of Cheryl Outen PhD LPC LLC to provide mental health services to me via the secure telehealth platform.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth. As always, my insurance carrier will have access to my medical records for quality review/audit.

Technology:
I understand that I will need to download an application and/or software to use this platform. I also need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. I also understand that in case of technology failure, I may contact Cheryl Outen PhD LPC LLC via phone to coordinate alternative methods of treatment.

Financial Obligation: I understand that I will be responsible for any copayments or coinsurances that apply to my telehealth visit. Fees associated with telehealth appointments are payable by credit or debit card only. If fees are associated with my telehealth services, I agree to have my credit/debit card information on file with Cheryl Outen PhD LPC LLC.

My card will be billed the same day as my scheduled telehealth appointment. If my card is declined, Cheryl Outen PhD LPC LLC will cancel my appointment and I will be charged in accordance with the cancellation policy. (Client Initial: _____)

I have had a direct conversation with Dr. Outen during which I had the opportunity to ask questions in regard to this treatment modality. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

Clients using insurance: I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pockets costs may be. I authorize insurance benefits to be paid directly to Cheryl Outen PhD LPC LLC and that Dr. Outen may release any information to my insurance provider required for processing my claims. (Client Initial: _____)

Self-Pay clients: I am aware of the fees associated with telehealth appointments and agree to pay at the time of my appointment. I understand that I am responsible for cancelled telehealth appointments in accordance with the Dr. Outen's cancellation policy as documented by my signature on the Informed Consent. (Client Initial: N/A)

I understand that I have the right to withhold or withdraw my consent to the use of telehealth services in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Dr. Outen. As long as this consent is in force (has not been revoked), Dr. Outen may provide health care services to me via telehealth without the need for me to sign another consent form.

Dr. Cheryl Outen, LPC
Telehealth Informed Consent

By signing this form, I certify:
 that I have read or had this form read and/or had this form explained to me;
 that I fully understand its contents including the risks and benefits of the procedure(s); and
 that I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

My signature below indicates my informed and willful consent to treatment using this platform.

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Parent/Guardian/Legal Representative Signature (if minor or needed otherwise)	Printed Name	Date