Sarah Gentry, LMHC, CAP, CRRA

TELEHEALTH CONSENT

"TeleHealth" means that you will be evaluated and treated by a health care provider or specialist from a distant location via electronic communication. Since this may be different than the type of care with which you are familiar, it is important you understand and agree to the following statements:

- The consulting health care provider will be at a different location from me.
- I understand there are potential risks to this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. I understand there are alternatives and limitations to this type of care. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if it is felt that the videoconferencing connections are not adequate for my situation.
- I understand that I may be released before all my medical problems are known or treated and it is my responsibility to make such conditions or symptoms known to the medical personnel as well as to make arrangements for follow-up care.
- I understand that payment will be collected at the time of service and cannot be refunded once care has begun.

Authorizations

- The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows: By typing my name below, I am granting permission to my therapist to perform and administer care and treatment of the patient, or designated other qualified health care provider for such services.
- Grants permission to release to third party payor(s), insurance if warranted, representatives and/or physician(s) involved in the patient's care, any information needed in connection with all care rendered to patient.
- If the patient is under the age of 18 or lacks capacity, the signing party affirms that they are either the parent or legal guardian of such patient and has full legal authority to seek medical assistance on behalf of the patient.

Financial Responsibility

I understand that payment is due at the time of session and I authorize payments directly to **Sarah Gentry, LMHC, CAP, CRRA.**

I understand and agree to the statements above.

Signature of patient and or guardian (if under 18):

_____

Signature of parent or financially responsible person (if necessary):

_____

Thank you!

Sarah Gentry, LMHC, CAP, CRRA

MH#9710 NPI #1548826522 EIN# 83-1702037 CAQH# 1460613