Collaborative
Counseling & Psychiatry

2401 Harnish Drive, Suite 100
Algonquin, IL 60102

2210 Dean Street, Unit D
St. Charles, IL 60175

Telehealth Consent

I hereby authorize Collaborative Counseling & Psychiatry and its associates to use live video and/or telephone calls as a means for Telehealth psychotherapy and medication management appointments in accordance with all applicable laws, rules, and guidelines.

I understand that Collaborative Counseling & Psychiatry currently uses Doxy.me, which is a HIPAA compliant video platform, as the preferred method of conducting Telehealth appointments.

I understand that it is my full responsibility to protect my own mental and physical health information during Telehealth appointments by ensuring my own privacy for the entire duration of the appointment.

I am aware that Telehealth may not be covered by my insurance company and that I am responsible for any fees incurred during psychotherapy and medication management appointments which utilizes Telehealth as a communication method to conduct my appointment.

I understand that I may revoke this authorization at any time. I may specify the date, event, or condition on which this consent expires on the day of or after the desired date. I understand I may not revoke my consent for any services rendered prior to the date of revocation. I understand that if I do not specify an expiration date, this consent will remain in effect as long as I am a client at Collaborative Counseling & Psychiatry.

Date: _____

Signature: _____
Signature of patient or responsible party if patient is a minor or is otherwise unable to sign for themselves.

_____
Printed Name of Patient or Responsible Party

_____
Capacity of Responsible Party (e.g., parent, guardian, etc.)