Consent & Statement of Understanding:
Audio/Visual Sessions

Client Information

Name _____ Date of Birth_____

Home address_____ Zip_____

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

I hereby authorize HCT and its associates to use Doxy.me (HIPAA-compliant), or other HIPAA-compliant platforms for telecommunication, as a means for psychotherapy. 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 contacting my insurance company to determine coverage, including any fees that would be incurred during psychotherapy which incorporates telecommunication.

I understand that I may revoke this authorization at any time by giving written notice, except to the extent HCT 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.

_____ _____
Client Name (printed) Date

_____ _____
Client's signature (age 12 and older) Date

_____ _____
Parent/guardian of minor OR of legally disabled recipient Date