CONVENTIONS
PSYCHIATRY & COUNSELING
1560 Wall Street, Suite 304, Naperville, IL 60563
Phone: (630) 416-8289 Fax: (630) 416-8306

Interactive Audio and Visual Consent Form

- Telehealth, Telepsychiatry, and Teletherapy is the use of electronic transmissions to treat the needs of a patient. This means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio/video. Telehealth may occur from different locations geographically in order to assist with delivery of care, when access to care may not be possible by face-to-face visits.

- Telepsychiatry and Teletherapy at Conventions Psychiatry & Counseling can only occur in the state in which providers are licensed.

- If Telehealth is not in your best interests, your provider will suggest alternative options better suited to your needs. Telepsychiatry and Teletherapy are not intended for emergency services. If emergencies arise, you will be required to seek face-to-face consultation and evaluation. By signing this consent, you agree to seek such care if you or your provider deem this necessary. In the event of an imminent emergency, clients should consult the nearest emergency room, or call 911, to receive emergent care. Telehealth is not available for initial evaluations.

- Telepsychiatry and Teletherapy via ZOOM* is considered to be secure because it is reported by the manufacturer to be encrypted and confidential and meets HIPAA acceptable privacy guidelines. Despite the manufacturer's representation, Conventions Psychiatry & Counseling does not independently certify that it meets encryption criteria for HIPAA compliance, and therefore you release Conventions Psychiatry & Counseling, and their contracted providers, from any liability in the event that teletherapy via ZOOM* is not secure and confidential as reported by the manufacturer.

- Telepsychiatry and Teletherapy may be received from your chosen environment (e.g., home or work). You understand that you are responsible for (1) providing the necessary computer, telecommunications equipment and internet access for Telehealth sessions; (2) the information security on your computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions and intrusions. You will be required to inform your provider if any other person can hear or see any part of the session. Your provider will inform you of the same.

- Payment for Telepsychiatry and Teletherapy must be determined in advance with your provider or the practice. Some insurance companies, although not all plans, reimburse for Telepsychiatry and Teletherapy. It is the client's responsibility to understand their coverage and obtain authorization for these services. Conventions Psychiatry and Counseling can offer assistance with obtaining authorization, if you so request. Please discuss your coverage with your provider and/or whether you can participate in these services at the agreed upon self-pay rate. A credit card must be kept on file for payment at the time of service, or payment must be made prior to the session.

I have read, understand and agree to the information provided above. I understand that my typed signature shall have the same legal and binding authority as my handwritten signature.

Patient Name _____ Date of Birth _____

Patient Signature _____ Date _____

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Self- Pay Agreement

The Self-Pay Agreement is intended to provide Self-Pay patients/legal guardians with an understanding of the financial aspect of healthcare services provided at Conventions Psychiatry & Counseling. The patient/legal guardian will be responsible for full payment of charges at the time of services.

The patient has been registered as Self-Pay due to the following reasons marked below:

- ☐ The patient/legal guardian does not have insurance coverage.

OR

- ☐ The provider performing services or therapies is not a participating provider with my health insurance. Therefore, these services/therapies are not covered by my policy.
  ___ Self-Pay (Insurance will not be billed for services)
- ☐ The scope of services rendered by this provider may not be covered by my health insurance policy.
  ___ Self-Pay (Insurance will not be billed for services)
- ☐ The appropriate authorization required by my health insurance policy has not been obtained from my primary care physician. It is my personal decision not to obtain the authorization from my primary care physician.
  ___ Self-Pay (Insurance will not be billed for services)
- ☐ No claim will be sent to my insurance since it is my personal decision not to use my health insurance benefits for the above services/therapies even though I understand that these services/therapies are considered covered by my policy (elect Self-Pay).

Conventions will not bill any insurance plan at a later date if the Patient/Legal Guardian elects to be Self-Pay at the time of service.

My signature below acknowledges receipt of the Self-Pay Agreement.

_____
Patient Name (Please Print)

_____
Patient/Legal Guardian Signature Date

Self-Pay Agreement explained by:

_____
Staff Name (Print) Date

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Authorization to keep credit card information on file

Patient Name:_____Date of Birth:_____

I authorize Conventions Psychiatry and Counseling to keep the following credit card(s) information on file.

Primary Card Account

_____
Name on credit card (Exactly as printed)

_____

_____
Billing Address City, Zip Code

_____
Credit Card Number

_____
Exp. Date CVV2#

_____
Signature Date

Secondary Card Account

_____
Name on credit card (Exactly as printed)

_____

_____
Billing Address City, Zip Code

_____
Credit Card Number

_____
Exp. Date CVV2#

_____
Signature Date

I authorize Conventions Psychiatry and Counseling to charge my credit card on file for balances indicated below:

- ☐ Co-payments
- ☐ Coinsurance
- ☐ Deductible
- ☐ Office Fees- Not limited to- No show fees, Cancelation fee, Prescription fee, self pay fee ect.

Since the payment amount may vary, I will be notified of the amount and date of the transaction.

This authorization is valid until I provide you with written cancellation.

_____
Signature Date