Bridge to Wellness Centers, LLC 1934 Old Gallows Road Suite 360
Phone (703) 752-6181
Fax (703) 752-6201

CONSENT to USE of TELECOMMUNICATIONS for PSYCHOTHERAPY

Date: _____ Client Name: _____

On behalf of myself or the client listed above, I hereby consent to engaging in telehealth, Doxy.me as a communication means for psychotherapy with Bridge to Wellness Centers, LLC. I understand that "telehealth" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of clinical data, and psychoeducation using interactive audio, video, or data communications.

I understand that, with my signed consent, telehealth may also involve the communication of my mental health information, both orally and visually, to other health care practitioners located in the Commonwealth of Virginia.

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 Bridge to Wellness Centers, LLC via phone to coordinate alternative methods of treatment. (Client Initial: _____).

Financial Obligations: Fees associated with telehealth appointments are payable by credit or debit card only. If fees may be associated with my telehealth services, I agree to have my credit/debit card information on file with Bridge to Wellness Centers, LLC. My card will be billed the same day as my scheduled telehealth appointment. If my card is declined, Bridge to Wellness Centers, LLC will cancel my appointment and I will be charged in accordance with the cancelation policy. (Client Initial: _____).

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 canceled telehealth appointments in accordance with the Bridge to Wellness Centers, LLC cancellation policy as documented by my signature on the Informed Consent. Initial Assessment/Intake = $200.00, Individual Therapy Sessions = $150.00, Follow-up Appointments per session = $150.00, Marital/Couples Therapy per session = $150.00.
(Client Initial: _____).

I understand that using the Telehealth platform allows access to mental health services that might not otherwise be available to me due to my mental health, and/or my physical, resource, or geographic limitations. Scheduling: I understand that scheduling is conducted through Bridge to Wellness Centers, LLC and is based on my provider's normal clinic hours. Telehealth appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the local county crisis line or by dialing 911. (Client Initial: _____).

Recording: As a general practice Bridge to Wellness Centers, LLC does not record telehealth sessions without prior permission. Confidentiality: The laws that protect the confidentiality of my clinical

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information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

Doxy.me is a HIPAA compliant platform for telecommunication. I understand that I have the following rights with respect to telehealth: 1. I have the right to withdraw my consent at any time. 2. I understand that there are risks and consequences associated with telehealth including, but not limited to the possibility, despite reasonable efforts on the part of my counselor/therapist/clinical intern, that the transmission of my clinical information could be disrupted or distorted by technical failures. In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my counselor/therapist/clinical intern believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to such services. (Client Initial: _____).

Date: _____ Signature: _____
Client or parent/guardian)

_____
Printed Name (Client or parent/guardian)

Date: _____ Signature: _____
(Clinician)

_____
Printed Name (Clinician)