Cheryl Wilczak Psy.D.

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Tele-therapy Informed Consent

I, _____, date of birth _____, hereby consent to engage in tele-therapy with Dr. Cheryl Wilczak. I understand that "tele-therapy" includes diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

I understand that I have the following rights with respect to tele-therapy:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to tele-therapy. 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.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from tele-therapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychologist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that if my psychologist believes I would be better served by direct (i.e. face-to-face) interaction and if I am unable to meet with her face-to-face, I will be referred to a professional who can provide such services in my area.

(4) I understand that I may benefit from tele-therapy, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with Connecticut law.

(6) I understand that I must give 24 hours notice when cancelling or rescheduling a session or will be charged for the full price of the session.

(7) I understand that I am responsible for contacting my insurance company to verify coverage and paying all fees not covered.

I have read and understand the information provided above. I have discussed it with my psychologist, and all of my questions have been answered to my satisfaction.

_____ Signature of client/parent/legal guardian Date:_____

Harbor Bridge Emotional Health, LLC
NEW CLIENT CONSULT

Today's Date: _____ ADULT or CHILD_____

CONFIDENTIAL

Please Print Legibly. Information Remains Strictly Confidential within the applicable law.

_____
Client First Name MI Last Name

Home Phone_____ Day Phone _____Phone, Other _____

Mailing Address _____

_____

SS# ____ - ____ - _____ Date of Birth _____ Gender _____

My Medical Doctor is _____

Emergency Contact

_____
Name Relationship to Client Phone

Client Email: _____

Credit Card Authorization Form

I authorize Harbor Bridge Emotional Health to use the credit card on this form to charge my fees for therapy.

Client first and last name

Cardholder name if different from client name

Street Address

City State Zip

Card Type (Amex, Visa or Mastercard) Card Number

CVV or Security Code Expiration Date

Signature Date