JOHN R. DAY & ASSOCIATES,
CHRISTIAN PSYCHOLOGICAL ASSOCIATES

INFORMED CONSENT FOR TELEHEALTH

I understand that John R Day & Associates provides psychological services, such as psychological testing, psychotherapy (also referred to as counseling), and follow up visits as needed. I understand that these services may include Teleheath, depending upon what my insurance allows.

> [Telehealth are therapy sessions through real time video. We use Doxy.me, which is a HIPAA approved video program. Telehealth may be recommended by insurance or the therapist when a patient cannot come into the office for any reason. Telehealth sessions are not recorded. Telehealth sessions are billed as any other therapy sessions.]

I understand that each psychologist or therapist has different specialties and will utilize these skills for treatment. By signing below, I am giving consent for psychological services provided by John R Day & Associates.

I understand that I am responsible for my bill for services provided and that payment is due upon completion of service. If I expect any portion of my bill be reimbursed or paid by insurance or prepaid health plan, it is my responsibility to ensure that my therapist has met my carrier's requirements. **It is my responsibility to ensure that my insurance covers Telehealth before utilizing this service.**

I authorize payment directly to John R. Day & Associates, Christian Psychological Associates Ltd., on all my insurance admissions. I authorize the release of information of my care to my insurance companies to help obtain payment from them. I authorize my insurance company and my therapist to obtain any information they require to fulfill this function. This authorization will remain in effect until revoked by me in writing.

I understand my rights and responsibilities as a client at John R. Day & Associates, Ltd./Christian Psychological Associates. I understand the nature of my rights to confidentiality, as well as the financial policies of the practice as contained in the Financial Policy that I have received.

_____ _____
Patient/Responsible Party Signature Date

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Printed Name of Patient