KENFIELD WALTERS INTL LLC
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TELEMEDICINE/TELEPSYCHOLOGY & FACE-TO-FACE SERVICES INFORMED CONSENT AND LIMITS OF CONFIDENTIALITY FOR EVALUATION AND TREATMENT

Kenfield Walters Intl LLC provides psychology services to individuals and corporations. Services include assessment and evaluations, as well as diagnostics and treatment planning and delivery.

Patient Name:_____ Provider Name: Judith C. Walters, Ph.D. LP

1. By signing this form, I _____consent to the use and disclosure of my protected health information for assessment, treatment, payment, and related services and this consent applies to Kenfield Walters Intl LLC (KWI) and to the KWI Psychologist. I understand that I have the right to revoke this consent, in writing, except where KWI or KWI Provider has already made disclosures in reliance on my prior consent.

2. I hereby consent to engage in Telepsychology (aka Telemedicine) or face-to-face sessions with the KWI provider named above as part of my treatment. I understand that "telemedicine, “as with in-person services, includes the practices of mental health diagnosis, consultation, assessment, evaluation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and in written form. A Release of Information Form must be signed, unless, in accordance with law, unusual circumstances warrant timely disclosure for safety or insurance purposes.

3. I understand that there are risks and consequences from telemedicine despite reasonable measures taken by my therapist including, but not limited to, failure of transmission/audio or video streaming of my session; information disruption or distortion by technical failures; or interruption of session transmission by unauthorized persons; and/or access to my medical information by unauthorized persons. In addition, I understand that telemedicine-based services and care may not be as comfortable as face-to-face services. I also understand that if my KWI Provider believes that I would be better served by face-to-face services, I will be seen in the office by the KWI Provider, or I will be referred to a KWI-approved Provider, or I will seek a therapist through my insurer.

4. I understand that the progress and outcomes of treatment are dependent on my own efforts. I accept that therapy may include brief periods when I feel that I am not moving forward. This is typical and I agree to discuss this with my provider.

5. I have been informed and accept that the payment guidelines issued by my insurer are the same, or approximate those applied to face-to-face treatment. I agree to check on my benefits with my insurer if I have questions. In EAP insurance cases, I understand that it is my responsibility to track session usage. I acknowledge that KWI requires payment of my co-pays and deductible, if applicable, at the time of services. I acknowledge that KWI does not carry unpaid balances and that my insurer may not cover some services, and that I am personally responsible for these payments. I agree to inform KWI immediately if my insurance information changes. I agree to pay $80.00 for missed sessions if I fail to provide to KWI notification of change 48 hours prior to a scheduled session.

6. By signing this form, I acknowledge that I have been informed of limits to confidentiality and payment policies and I voluntarily agree to Telehealth and face-to-face services provided by KWI.

Please sign below indicating that you have read and agree to the above.

_____ _____

Patient/Guardian Date