



CHAT N RELAX COUNSELING & CONSULTATION, LLC
DaRon Stephens, LMHC, MCAP
FLORIDA
(P) 201-675-1083

Telehealth – Informed Consent & Acknowledgment

Client: _____ DOB: ____/____/____

Telehealth service is provided exclusively for Florida residents.

Scheduling

Your scheduled sessions will remain the same as they would in office. The only difference is we will have our session via a HIPAA compliant audio/video service. You must connect with me at your scheduled time to have your session. If no call/contact within the first 10-minutes of your scheduled time, your session will count as a no-show and the no-show fee will be applied. Please be advised that **ALL** attendance policies, requirements, treatment compliance agreements, etc. noted in Chat N Relax Counseling & Consultation, LLC’s Treatment Informed Consent will apply to Telehealth Mental Health Services effectively March 13th 2020. You will be closed if you do not maintain your session attendance.

Payments

Your copayment/coinsurance/deductible, etc. will remain the same for this service as in office as long as your policy is active unless otherwise noted by your policy. If you plan to pay by cash, check or money order, **your payment will be due at your next office session** in addition to your current scheduled copayment. Please discuss with me other options if neither cash, check, or money order is available to you to pay for your services.

For self-pay and/or no insurance clients: You will have the same payment options as noted above.

Wellness Check Acknowledgment

Due to telehealth (remote/virtual) services being off site/out of physical office contact, if any of these scenarios apply, a ***wellness check call*** will be placed to your local crisis screening center and/or police department. Your emergency contact will also be contacted:

- In the event I visually notice and/or you clearly or explicitly reveal a psychiatric or mental health concern that requires immediate intervention.
- Expression of self harm to self and/or others with clear intention/plan.
- If the telehealth services are abruptly disconnected by you or other means & I cannot reach you by telephone to verify wellness immediately after.

By signing below, you are acknowledging this Wellness Check if applicable.



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Confidentially/Privacy

I will provide the same level of confidentiality & privacy as I would in office for our session. I cannot control the confidentiality & privacy on your end during our Telehealth-Mental Health Service. Please be advised that during your scheduled time for session, you must secure your background and/or environment to protect your own confidentiality & privacy. I am not liable for anything someone may hear you or I say if you do not take the necessary steps to protect your confidentiality on your end of the Telehealth-Mental Health Service. By signing below you fully understand and is aware that you must take precautions to protect your confidentiality & privacy on your end of the Telehealth-Mental Health Service. You also waive any rights to pursue any legal action against DaRon Stephens, LMHC, MCAP, Owner of Chat N Relax Counseling & Consultation, LLC & Chat N Relax Counseling & Consultation, LLC itself in the event your confidentiality & privacy is not protected on your end during Telehealth-Mental Health Service.

As always, please feel free to contact me if you have any questions.

I have fully read and understood the Informed Consent & Acknowledgment of Telehealth-Mental Health Service.

Print

Date

Signature

Date

Phone: _____

Email: _____@_____

- Insurance Carrier: _____
- Self-Pay/No Insurance

DaRon Stephens, LMHC, MCAP

Date