DEL MUNDO
PSYCHOLOGICAL, APC

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AGREEMENT FOR TELEHEALTH SERVICES / INFORMED CONSENT TELEHEALTH SERVICES

Introduction
This Agreement is intended to provide _____ (herein "Client") with important information regarding the practices, policies, and procedures of Del Mundo Psychological and its providers (herein "Therapist") regarding telehealth. Telehealth includes clinical consultation, treatment, transfer of medical/psychiatric data, emails, telephone conversations, and education using interactive audio, video, or data communications and is not the same as a direct Client-Therapist visit.

Risks and Limitations of Telehealth
Client is advised that participating in telehealth may involve certain risks and limitations. Despite reasonable efforts by Therapist, the transmission of information via telehealth could be disrupted or distorted by technical failures or interrupted by unauthorized persons. Furthermore, electronic storage of Client's medical information could be accessed by unauthorized persons.
Additionally, telehealth services may not be as complete as face-to-face services. If Therapist believes Client would be better served by another form of therapeutic service, Client may be referred to another mental health professional that can provide such services to Client. Finally, although Client may benefit from telehealth, results cannot be guaranteed.

Confidentiality
The information disclosed by Client is generally confidential and will not be released to any third party without written authorization from Client, except where required or permitted by law. Exceptions to confidentiality, include, but are not limited to, reporting child, elder, and dependent adult abuse, when a client makes a serious threat of violence towards a reasonably identifiable victim, or when a client is dangerous to him/herself or the person or property of another.
Telehealth by SimplePractice is the HIPPA compliant technology services used for videoconferencing appointments. If using this platform, Client agrees to not share Client's appointment link with anyone.

Fee and Fee Arrangements
The usual and customary fee for service is $160 per 45-minute telehealth session. Sessions longer than 45 minutes are charged for the additional time pro rata. Therapist reserves the right to periodically adjust this fee. Client will be notified of any fee adjustment in advance. In addition, this fee may be adjusted by contract with insurance companies, managed care organizations, or other third-party payors, or by agreement with Therapist.
The agreed upon fee between Therapist and Client is _____ per 45-minute session. Therapist reserves the right to periodically adjust fee. Client will be notified of any fee adjustment in advance.
Clients are expected to pay for services at the time services are rendered. Therapist accepts cash, checks, major credit cards, and in some cases, FSA/HSA cards.

Therapist Availability
Telehealth does not include emergency services. Therapist's office is equipped with a confidential voicemail system that allows Client to leave a message at any time. Therapist will make every effort to return calls within 24 hours (or by the next business day) but cannot guarantee the calls will be returned immediately. Therapist is unable to provide 24-hour crisis service. In the event that Client is feeling unsafe or requires immediate medical or psychiatric assistance, he/she should call 911 or go to the nearest emergency room.

Client should also be aware of the following resources that are available in the local community to assist individuals in crisis:

Crisis Hotline: 877-727-4747	Youth Shelter: 949-494-4311	Domestic Violence Help: 800-799-7233
Rape Crisis Hotline: 714-957-2737	Hospital: 714-771-8113	General Resources: 211

Acknowledgement

By signing below, Client acknowledges that he/she has reviewed and fully understands the terms and conditions of this Agreement. Client has discussed such terms and conditions with Therapist, and has had any questions with regard to its terms and conditions answered to Client's satisfaction. Client agrees to abide by the terms and conditions of this Agreement and consents to participate in psychotherapy with Therapist. Moreover, Client agrees to hold Therapist and Del Mundo Psychological free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment. Client may withhold or withdraw consent to telehealth at any time. I understand that I am financially responsible to Therapist for all charges, including unpaid charges by my insurance company or any other third-party payor.

☐ By checking this box and providing the information below, I authorize Therapist to keep the following credit card information on file and to charge credit card on file for payment of services rendered, missed appointments or appointments canceled/rescheduled without 24 hours notice, copays, and outstanding balances.

Credit Card #:_____

Expiration Date: _____ Billing Zip Code: _____ Security Code: _____

_____	_____	_____
Client Name (please print)	Signature of Client (if 12 and older)	Date
_____	_____	_____
Legal Guardian Name (please print)	Signature of Legal Guardian (for minor clients)	Date
_____	_____	_____
Legal Guardian Name (please print)	Signature of Legal Guardian (for minor clients)	Date