BLAIR WELLNESS GROUP, A PROFESSIONAL PSYCHOLOGICAL CORPORATION
Dr. Cassidy Blair, Psy.D.

Consent for Email and/or Text Message Communication

Email and text messaging allows health care providers to exchange information efficiently for the benefit of our patients. At the same time, we recognize that email and text messaging are not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or during transmission.

HIPAA requires that providers take reasonable steps to protect against these risks but acknowledges that a balance must be struck between the need to secure protected health information (PHI) and the need to ensure that clinicians can efficiently exchange important patient care information. My practice has implemented such measures through obtaining informed consent from patients using any potentially unencrypted electronic format.

Please practice discretion and best judgment when using email or text messaging. Most common and appropriate uses of these forms of communication include:

1) Scheduling or rescheduling of appointments
2) Prescription related issues
3) Brief clinical questions
4) Billing related communication - including the sending of invoices and Superbills

Email or text messaging should not be used for:

1) Emergency situations. Under these circumstances, call 911
2) Disclosure of sensitive information that should otherwise be discussed during regular appointments

If you would like to use email and/or text messages that may contain your protected health information, please complete and sign this Consent below. You are not required to authorize the use of email and/or text messaging and a decision not to sign this authorization will not affect your health care in any way. If you prefer not to authorize the use of email and/or text messaging, I will continue to use U.S. Mail or telephone to communicate with you.

_____ _____
Patient's Signature Date

_____
Name (please print)

_____
Personal email address where Blair Wellness Group, A Professional Psychological Corporation may send you your health information (please print)

_____
Telephone number where Blair Wellness Group, A Professional Psychological Corporation may text you your health information (please print)

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TELEHEALTH CONSENT FORM

I, _____(Patient) hereby consent to engage in Telehealth with Blair Wellness Group, A Professional Psychological Corporation, PSY22022.

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g., Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the [Informed Consent Form or Statement of Disclosures] I received from my therapist also apply to my Telehealth services.

2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

3. I understand that miscommunication between myself and my therapist may occur via Telehealth.

4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.

6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.

7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.

9. I have discussed the fees charged for Telehealth with my therapist and agree to them, and I have been provided with this information in the [Informed Consent Form, Name of Payment Agreement Form, or Credit Card Processing Agreement].

10. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

[For conjoint or family therapy, patients may sign individual consent forms or sign the same form.]

_____ _____

Patient's Signature Date

_____

Patient's Printed Name

Verbal Consent Obtained Therapist reviewed Telehealth Consent Form with Patient, Patient understands and agrees to the above advisements, and Patient has verbally consented to receiving psychotherapy services from Therapist via Telehealth.

_____ _____

Therapist's Signature Date

BLAIR WELLNESS GROUP, A PROFESSIONAL PSYCHOLOGICAL CORPORATION
Dr. Cassidy Blair, Psy.D.

Credit Card Processing Agreement

Name: _____

Payor's Name (if different than the above):_____

_____
Credit Card Number

_____
Security Code (3 digits for Visa, MC, Discover; 4 digits for Amex) / Expiration Date / Billing Zip Code

_____
Email address or text message phone number for transaction receipts

I hereby authorize Blair Wellness Group, A Professional Psychological Corporation. to use the above credit card, including circumstances where the credit card is not present. This credit card can be used to pay for services rendered and for any outstanding balances on this client/patient's account. Charges will be made for services as described in the "Fee Schedule," including fees for scheduled appointments, charges for missed appointments or late cancellations, and for fees associated with services provided outside of scheduled appointment times. This authorization is good through the credit card expiration date.

If charges are disputed and reported to your credit card company, I agree to allow Blair Wellness Group, A Professional Psychological Corporation. to contact my credit card company and disclose the purposes of the disputed charges, which may include information regarding attendance or cancellations of appointments.

_____ _____
Authorized Signature Date