VIESCA

THERAPEUTIC SERVICES

Viesca Therapeutic Services, PLLC
600 Round Rock West Dr., #606, Round Rock, TX 78681
(512) 293-4346 | aviesca@viescatxs.com |
www.viescatxs.com

# Telehealth Therapy Consent

Name: _____ _____ _____
First Name Middle Name Last Name

Date of Birth: _____ _____ _____
MM DD YYYY

- I understand that my health care provider is offering to provide telehealth services.
- My health care provider has explained to me how the HIPAA compliant video conferencing technology will be used to conduct such an appointment, and that it may be different from a face-to-face visit due to the fact that I will not be in the same room as my health care provider.
- I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can stop the telehealth appointment if it is felt that the videoconferencing connections are not adequate for the situation.
- I have had the alternatives to a telehealth appointment explained to me and am choosing to participate in a telehealth therapy appointment.
- I have had an opportunity to have a direct conversation with my health care provider, during which I had the opportunity to ask questions about this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
- I understand that it is my responsibility to contact my insurance company to find out if there are telehealth benefits, and if they require a specific software platform for services. I understand that my provider may not be using the platform required by my insurer. If my insurance policy has no telehealth benefits, or will not pay for the telehealth platform my provider is using, and I still wish to engage in telehealth therapy, I agree to the following private pay rates: 30-minute session - $65; 45-minute session - $125; 60-minute session - $150.
- I can withdraw my consent to telehealth services at any time by submitting a written request to: Viesca Therapeutic Services, PLLC 600 Round Rock West Dr. #606, Round Rock, TX 78681.

_____ _____
Signature Date of Signature (MM/DD/YYYY)