

**Consent & Statement of Understanding: Audio/Visual Sessions
(A.K.A TeleTherapy/TeleHealth)**

Client Information

Name _____ Date of Birth _____

I hereby authorize Willow Tree Wellness, LLC and its associates to use Doxy.me as a means for medication management. Doxy.me is a HIPAA compliant platform for telecommunication. I further attest that since I have chosen this form of communication, I have been advised that it may not be covered by my insurance company and that I am responsible for any fees incurred during medication management which incorporates telecommunication.

I understand that I may revoke this authorization at any time by giving written notice, except to the extent Willow Tree Wellness, LLC has already taken action in reliance on it. I may specify the date, event, or condition on which this consent expires. If none is stated, and if no prior notice of revocation is received, this consent will expire one year after the date it was initiated.

Client's signature (age 12 and older) Date

Parent/guardian of minor OR of legally disabled recipient Date

Therapist's signature Date

CREDIT CARD ON FILE

Payments are due at the time of service. Willow Tree Wellness, LLC recommends a credit, debit, or flex spending/HSA card on file. The credit card on file can be used in order to pay for any copays, co-insurance, deductibles, no shows/late cancellations or out of pocket payments if no other payment method is used at the time of the session or if a late cancellation or no show is incurred (the credit card on file will be charged our \$50.00 on the day of scheduled session for no-show and late cancellations). Clients may also pay by cash or check at each session. Your credit card will be stored in a HIPAA compliant electronic health system and this document will be safely destroyed.

Please check the box and sign below:

Please charge my card for charges in full for sessions at the time of service.

Client Name:		
Cardholder Name:		
Credit Card Number:		
Expiration Date:	Billing Zip Code of Credit Card:	Security Code:
Cardholder's Signature:		Date:

I understand that by signing above, I am authorizing Willow Tree Wellness, LLC to charge my card in the manner indicated by my initials above. These balances may include copays, co-insurance amounts, out of pocket payments, deductibles, no show or late cancel fees.

