

Nicole T. Shiraev, LICSW, PLLC
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Consent For Telehealth Services

Patient Name: _____

Patient Date of Birth: _____

Preferred Email Address: _____

Preferred Phone Number: _____

As a patient of Nicole T. Shiraev, LICSW I, _____, consent to the use of telehealth services through Google Meet, a HIPAA compliant telehealth platform. And in consenting to these services I agree to the following terms:

- Telehealth services are for established clients who are occasionally unable to attend in-person office visits, individual clients (adolescents 16+ and adults only; adolescents who reside at home must have consent from a parent/guardian).
- Telehealth services are charged at the rate of \$125.00/hour if opting to pay out of pocket for this service or based on the assigned rate from insurers with whom I have an established contract. Clients are ultimately responsible for being aware of their health benefits and to accept responsibility for fees associated with services received. Copays/coinsurance payments/deductibles apply.
- Both the client and the provider must be in Washington State where the provider is licensed.
- Telehealth services will be offered through the provider's office at this time and during standard office hours (M-W, 9 AM-5 PM). Telehealth services will not be available during scheduled or unscheduled practice closures. **Exception to this rule: During COVID-19 and while the provider must adjust work schedule to meet both patients' needs and attend to the provider's own family responsibilities, the provider will offer some 8 AM appointments, 5 PM appointments, and more flexible scheduling on weekends.**

- When attending a telehealth session, clients are expected to be mindful of attire and their environment. Clients are expected to dress in a similar manner as they would when attending in-person sessions. Clients should take steps to minimize potential distractions during sessions, take steps to protect their own privacy, and consider what portions of their home/office/other environment they wish/don't wish to be viewable to me during telehealth services. **I am not liable for any potential confidential information that may be over-heard by another party (e.g., loved one, co-worker, other third party) in the space (office/home) that the client is physically in at the time of the telehealth session. The client assumes responsibility for controlling their environment in this circumstance.**
- I am a mandated reporter and I am required by law to report any actual or suspected abuse/neglect to children or vulnerable adults to child protective services (CPS) and adult protective services (APS).
- I am required by law to notify appropriate parties if I believe you are at imminent risk to yourself or to others. Such parties may include an emergency contact or local emergency services.
- No-show and late-cancellation fees apply for telehealth services as they do for in-person office visits. All other office policies apply as stated in the standard consent for services and state disclosure form all clients sign/have signed at the start of services with Nicole T. Shiraev, LICSW. (Exception: During the COVID-19 outbreak affecting Seattle and Western Washington beginning in February 2020: late cancellation fees will not apply to those cancelling as a result of a situation related to the COVID-19 outbreak. Reasonable exceptions for technological problems/errors that are beyond our control will also lead to waiver of such fees).
- Preferred email address as requested above will be used so that I can send you the appropriate link that will allow you to join the telehealth session. The preferred phone number will be used in the event that I need to reach you to address any challenges we may experience in connecting using the Google Meet application and/or in the event of any scheduling changes.
- If you have provided me with your insurance plan information and have already authorized me, on the new client registration form you completed when you started care, to submit claims with your insurer on your behalf then I will assume permission to submit claims for telehealth services. If you prefer that I not bill your insurance for services please let me know in writing.

- Though I have taken every step to abide by HIPAA practices and best standards in the use and application of telehealth services, like all services and communications provided that use electronic transmission of data there remains some risk that a breach of privacy could occur. By choosing to use telehealth services you, the patient, accept responsibility for the information you choose to share through this medium and the inherent risk involved.

Client Signature: _____

Client name (Print): _____

Parent/Guardian Signature: _____

Date: _____