AMMIRATI COUNSELING
Empowering Your Relationships

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Authorization and Statement of Understanding for Teletherapy Sessions

Client Information

Name _____ Date of Birth _____

Home Address _____ Zip _____

Phone (Work) _____ (Home) _____ (Cell) _____

Email Address _____

I hereby authorize Ammirati Counseling and its associates to use different forms of telecommunication as a means for psychotherapy. I understand that some forms of telecommunication do not meet the standards set forth by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and that there is a greater risk to privacy than with traditional psychotherapy. However, whenever possible, Ammirati Counseling will find a platform that meets HIPPA requirements. 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 psychotherapy which incorporates telecommunication.

I understand that I may revoke this authorization at any time by giving written notice, except to the extent that Ammirati Counseling 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

_____ _____
Witness Signature Date