CONFIDENTIAL

HOFSTRA UNIVERSITY
Saltzman Community Services
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Credit Card Payment Authorization Form

For your convenience, we accept MASTERCARD and VISA credit cards only as payment for evaluation and instructional services rendered at the Psychological Evaluation Research and Counseling Clinic.

To process the payment, submit the following information:

Card Holder's Name: _____

Client's Name (if different): _____

Email: _____

Telephone: _____

Credit Card Type (check one): ☐ Mastercard or ☐ Visa

Credit Card Number: _____ - _____ - _____ - _____

Credit Card expiration Date: Month _____ Year _____

Payment Amount: _____

Cardholder Signature: _____

Date: _____

☐ **Please check here to allow Hofstra University to use this credit card for payment for services as they are provided. All credit card information shall remain CONFIDENTIAL.**

Joan and Arnold Saltzman Community Services Center

Psychological, Evaluation, Research and Counseling Clinic

Consent to Telehealth

I, _____, consent to participate in counseling sessions or communication via the internet, phone, email, and/ or videoconferencing (ZOOM) with the Psychological, Evaluation, research and Counseling (PERC) Clinic as described below.

By choosing to sign this form, I understand that the PERC Clinic cannot and does not guarantee the privacy or security of any session content or communication being sent through the internet, phone, email, or videoconferencing. There is potential that videoconferencing sessions via ZOOM, emails, phone calls, or voicemails can be intercepted and reviewed by others, and it is possible that there could be disruptions to therapy due to technological difficulties. I understand that communicating via these mediums is not 100% secure.

Although all text messages, voice mail and email are kept confidential, and theses communications platform are encrypted, choosing this method may lead to your information not being protected. If you choose to communicate with me in this manner, you must understand the risk and consent to using the designated email, cell and text below:

I consent to using **email** communication using the following email: _____

I consent to using **text** messages using the following cell number: _____

I consent to my therapist leaving me confidential voice mail messages on the above cell number:

YES ___

NO ___

Signature of Patient or Parent/Guardian: _____ Date: _____

Signature of Provider: _____ Date: _____

INITIALS _____

Psychological, Evaluation, Research and Counseling Clinic

Consent to Telehealth

The following information pertains specifically to the use of **videoconferencing**. Use of videoconferencing is completely voluntary and is an option we can discuss if you are interested.

• ZOOM is an online communication tool allowing for face-to-face video and it is **HIPAA compliant**. For more information about ZOOM security and privacy, please see: ZOOMcare.com

• ZOOM requires the use of a browser but does not require any software download.

• Appointments will be made via email, phone or text. It is important to be on time. We ask that you join the scheduled videoconference meeting a few minutes before the scheduled time to minimize delays. You will be in a virtual waiting room before the session begins.

• Confidentiality should be treated like an in-office session: no outside distractions, silence your cellphones, and close other programs on your computer. Please make sure you are alone in a quiet room, with the door closed.

•If you need to cancel or change your telepsychology appointment, you must notify your therapist in advance by phone or email

• For best picture and audio quality, a hardwired connection (via LAN cable) rather than a wireless one should be used if possible. Headphones add additional security.

• We will charge you for remote tele-therapy sessions at your regular rate.

• You agree to work with the PERC Clinic to come up with a safety plan, that includes at least one emergency contact (this may be an update from the information from the initial intake information) and the closest emergency department or service to your location, in the event of a crisis situation during our sessions.

• You understand that the PERC Clinic may decide to terminate video therapy services, if we deem it inappropriate to continue therapy through video session with you. In this case, we will discuss alternate treatment options with you

• If you are not an adult (18 years old or older), we will need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.

I also understand the following limitations of ZOOM video therapy sessions:

• Any internet-based communication is not 100% guaranteed to be secure/confidential. You agree that the PERC Clinic should not be held responsible if any outside party gains access to the video feed.

• In a crisis or emergency situation that needs immediate attention, whereby you are considering seriously harming yourself or someone else, you will dial 911, or go to a mental health hospital/ER.

• Technical problems could occur. If the video call is disrupted, the therapist will call back within ten minutes. If reconnection cannot occur, the therapist will call you on your cell phone to complete the session. Therefore, you will need to provide a telephone number that we can reach you on during each session Cell #_____

INITIALS _____

I have been informed of and understand the risks and procedures involved with using the videoconferencing technology. I agree to the terms listed above and I hereby voluntarily consent to the use of this platform for therapy sessions with my provider. I agree that the PERC Clinic should not be held liable in the event that any outside party passes technology security and discovers personal or confidential information. This consent will last for the duration of the relationship with this clinic; I can withdraw my consent for a video therapy session at any time, and the PERC Clinic will work with me to find a suitable alternative.

Yes _____

No_____

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name (if applicable):_____

Signature of Patient or Parent/Guardian:_____ Date: _____

Signature of Provider: _____ Date: _____