INNERSIGHT
LLC
PRIVATE PRACTICE MENTAL HEALTH COUNSELING

TELEHEALTH CONSENT FORM

1. I hereby authorize Innersight LLC to use the telehealth practice platform for telecommunication for evaluating, counseling and communication.

2. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended. Earbuds are recommended for both parties to ensure privacy.

3. I accept that the professionals can contact interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.

4. I understand that my current insurance may not cover the additional fees of the telehealth practices and I may be responsible for any fee that my insurance company does not cover.

5. I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and in all of these, my information will be kept private.

Client Name:_____

Signature:_____

Date:_____