

Shoudt & Reilly Psychological Services, LLC.

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Consent & Statement of Understanding: Audio/Visual Sessions

Client Information

Name _____ Date of Birth _____

Home address _____ Zip _____

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

I hereby authorize Shoudt & Reilly Psychological Services and its associates to use Therasoftonline.com/Therasoft.com as a means for psychotherapy. Therasoft 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 psychotherapy which incorporates telecommunication.

I understand that I may revoke this authorization at any time by giving written notice, except to the extent Shoudt & Reilly Psychological Services 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