# Dr. Polacheck Therapeutic Services

**Consent to Treatment via telehealth**

I do hereby seek and consent to take part in the treatment by Dr. Matthew Polacheck using telehealth. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I understand and agree to receive telehealth services. Telehealth involves the delivery of health care services, including assessment, treatment, diagnosis, and education, using interactive audio, video, and data communications

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. It has been explained to me that Dr. Polacheck is currently not taking insurance and despite previously utilizing insurance companies he no longer directly works with them. He can and will provide me with a super bill if requested.

I am aware that I will not be in the same location or room as Dr. Polacheck and Dr. is licensed in the state in which I am receiving services. I will report my location accurately during each session.

Dr. Polacheck Notice of Privacy Practices ("Privacy Notice")

Dr. Polacheck will protect the privacy of my health information and will not use or disclose it except as permitted by law. By signing this Consent, I acknowledge receipt of the Privacy Notice and consent to Dr. Polacheck's use and disclosure of my health information in accordance with its terms. I understand that all existing confidentiality protections that apply to in-person treatment apply to telehealth services.

Payment Policy

I acknowledge, understand and agree that:

1. I will pay prior to or at time of service provided.
2. I will pay any outstanding balances and delinquent accounts.
3. Dr. Polacheck accepts payment through Zelle, Venmo, or Credit Card via IVY HIPPA protected .
4. Dr. Polacheck's individual session is billed at a rate of $300 per 60 minutes for individual treatment. Sliding scale is available and can be discussed.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist