WESTCHESTER LCSW
COUNSELING SERVICES, PLLC

914-250-3122
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Consent & Statement of Understanding: Audio/Visual Sessions

Client Information:

Name: _____ Date of Birth: _____

Home Address: _____ Zip Code: _____

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

I hereby authorize Westchester LCSW Counseling Services, PLLC to use Zoom as a means for psychotherapy. Zoom 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. 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 Westchester LCSW Counseling Services, PLLC 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 18 and older) Date

_____

Parent/Guardian Signature Date