Southeastern Success Center, LLC
125 Alpine Circle, Columbia, SC 29223
803-779-3548

TELEHEALTH INFORMED CONSENT

I _____ [name of patient] hereby consent to engaging in telehealth psychotherapy with Mary "Molly" Bridges, LPC, NCC, MAC of Southeastern Success Center, LLC as part of my psychotherapy .

I understand that "telehealth" includes the practice of healthcare delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications. I understand that, with my signed consent, telehealth may also involve the communication of my mental health information, both orally and visually, to other health care practitioners located in the State of South Carolina.

Technology: I understand that I will not need to download an application and/or software to use this platform. I do need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. I also understand that in case of technology failure, I may contact Molly Bridges at Midlands Psychiatry Services 803-779-3548 or Southeastern Success Center 803-728-2100 via phone to coordinate alternative methods of treatment. (Client Initial: _____)

Financial Obligations: Fees associated with telemedicine appointments are payable by credit or debit card only. If fees may be associated with my telemedicine services, I agree to have my credit/debit card information on file with Midlands Psychiatric Services and Southeastern Success Center, LLC. My card will be billed the same day as my scheduled telemedicine appointment. (Client Initial: _____)

Clients using insurance: I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pockets costs may be. I authorize insurance benefits to be paid directly to Midlands Psychiatric Services or Southeastern Success Center, LLC and understand Midlands Psychiatric Services and Southeastern Success Center, LLC may release any information to my insurance provider required for processing my claims. (Client Initial: _____)

Self-Pay clients: I am aware of the fees associated with telemedicine appointments and agree to pay at the time of my appointment. I understand that I am responsible for cancelled telemedicine appointments in accordance with the Midlands Psychiatric Services and Southeastern Success Center, LLC cancellation policy as documented by my signature on the Informed Consent/ Agreement for Individual Therapy. (Client Initial: _____)

Individual and Couples Therapy
Initial Assessment = $180.00 or fee as contracted with specific insurance companies
Follow-up Appointments per session = $150.00 or fee as contracted with specific insurance companies
Fee for cancellation without 24-hour notice or no show = $150 -not reimbursable through insurance

I understand that using the Telehealth platforms allows access to mental health services that might not otherwise be available to me due to my mental health, and/or my physical, resource, or geographic limitations. (Client Initial: _____)

Scheduling: I understand that scheduling is conducted through Midlands Psychiatric Services /Southeastern Success Center and is based on my provider's normal office hours. Telehealth appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to your local county crisis line or by dialing 911. The National Suicide Prevention Lifeline phone number is 1-800-273-8255 (TALK) (Client Initial: _____)

Video/Audio Recording: As a general practice Midlands Psychiatric Services and Southeastern Success Center, LLC DO NOT record Telehealth sessions without prior permission. (Client Initial: _____)

Confidentiality: The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. Southeastern Success Center, LLC's Telehealth platforms, Doxy.me and RingRX are HIPAA compliant to protect my privacy and confidentiality. (Client Initial: _____)

I understand that I have the following rights with respect to telehealth:

1. I have the right to withdraw my consent at any time.

2. I understand that there are risks and consequences associated with telemedicine including, but not limited to the possibility, despite reasonable efforts on the part of my counselor/therapist/clinical intern, that the transmission of my medical information could be disrupted or distorted by technical failures. In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my counselor/therapist/clinical intern believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) that cannot be provided by Southeastern Success Center, LLC, I will be referred to a counselor/therapist who can provide such services in my geographic area.

3. I understand that I may benefit from telehealth but that results cannot be guaranteed or assured.

4. I understand that Midland Psychiatric Services and/or Southeastern Success Center, LLC may not provide telehealth services to me if I am outside of the State of South Carolina, and I understand that I may access telehealth services from Midlands Psychiatric Services/Southeastern Success Center, LLC from within the State of South Carolina only.

5. I understand that I have a right to access my mental health information and copies of medical records in accordance with South Carolina state law.

I have read and understand the information provided above. I have discussed it with my counselor/therapist/clinical intern, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment using these platforms.

_____ _____
Client Signature Date

_____ _____
Client Guardian's Signature Date

_____ _____
Provider's Name & Signature Date