Bassi Psychological Services, Inc.

Consent & Statement of Understanding:
Audio/Visual Sessions

Client Information

Name _____

Date of Birth_____

Home address_____
Zip_____

Phone: (Work)_____ (Cell)_____

I hereby authorize Bassi Psychological Services, Inc. and its associates to use Doxy.me, Zoom, or TherapyNote as a means for psychotherapy. These are HIPAA compliant platforms 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 _____ 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