LIFE MANAGEMENT ASSOCIATES, LLC

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Informed Consent for Telehealth Services and Financial Agreement

Client(s) Printed Names: _____

Definition of Telehealth:
Telehealth involves the use of electronic communications to enable Life Management Associates, LLC clinicians to connect with individuals using live interactive video and audio communications. Telehealth includes the practice of mental health and substance abuse services delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I, the client, or parent/legal guardian of a minor child/children, understand that the client has the following rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information that the client has already signed also apply to telehealth. A copy of our Office Policies and Therapeutic Informed Consent can be provided.
2. The client has the right to withhold or withdraw consent to the use of telehealth during care at any time, without affecting the right to future care or treatment.
3. There are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the clinicians, that: the transmission of personal information could be disrupted or distorted by technical failures, the transmission of personal information could be interrupted by unauthorized persons, and/or the electronic storage of personal information could be unintentionally lost or accessed by unauthorized persons. Life Management Associates, LLC utilizes secure, encrypted HIPAA compliant audio/video transmission software to deliver telehealth via a platform chosen by Life Management Associates, LLC.
4. By signing this document, the client agrees that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If the client is in crisis or in an emergency, the client understands that he/she should immediately call the National Suicide Prevention Lifeline 1-800-273-8255 or 9-1-1 or seek help from a hospital or crisis-oriented health care facility in the immediate area, such as Western Montana Mental Health Services, 1-406-563-3413.

Payment for Telehealth Services:
Life Management Associates, LLC will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. The standard copay and/or deductibles would apply. If insurance does not cover telehealth, I, the client agrees to pay out-of-pocket. I, the client understands as stated in the financial agreement with Life Management Associates, LLC that I, the client will be held financially responsible for any services provided to me, the client.

Financial Agreement:
To make sure we are operating on the same agreement regarding sessions, we have defined the following guidelines. Once you have agreed upon an appointment time, you are responsible for that time. If you foresee that you cannot keep the appointment time, you will need to give us at least a 24-hour cancellation notice or you will be charged for the time. Medical emergencies are acceptable for short notice (please call our office at (406) 782-4778 and leave a message if you have a medical emergency cancellation).

Insurance coverage is a contract between you and your insurance company. It is your responsibility to know and understand the limitations on your plan's coverage. In some cases, we may be a party to this contract. Please ask if we are a participating member with your insurance plan. If we are not, reduced benefits, in addition to deductibles and copays may apply. We will handle your claim according to our agreement with your insurance company. You

must notify us of any changes in your coverage within 15 days of the change. We will not become involved in disputes between you and your insurance company (i.e., deductibles, co-payments, coverage changes, secondary insurance) other than to supply information as necessary. You are responsible for all non-contractual fees unpaid by your insurance company.

Authorization & Insurance Company Release of Information:

I/We hereby authorize Life Management Associates, LLC to disclose to my/our insurance company(s), only the following information: patient name, date(s) of service, service(s) provided, and diagnosis, to be used for the purpose of insurance evaluation and reimbursement, unless otherwise specified in a separate authorization to disclose additional clinical information.

This information will be disclosed to the insurance company from records whose confidentiality is protected by Montana and/or federal law. These regulations prohibit the insurance company from making any further disclosure of this information without prior written consent. I/We understand that I/we have no obligation whatsoever to disclose any information from my/our record. I/We understand that I/we may revoke this consent at any time by notifying Life Management Associates, LLC in writing and/or by specifying an event or condition upon which my/our consent will expire without revocation. I/We have read or had this form read and explained to me and I/we understand its contents.

I/We have read the above and fully understand the importance of this relationship. I/We have reviewed the terms in the document and agree to abide by the terms as outlined for services provided by Life Management Associates, LLC. With my/our signature I/we give my/our consent to Life Management Associates, LLC, to provide the necessary information for any and all billing of the services rendered.

Patient Consent to the Use of Telehealth and Financial Agreement:

I have read and understand the information provided above regarding telehealth, have discussed it with my clinician, and all my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained.

I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

I am providing verbal consent to the representative of Life Management Associates, LLC on this date: _____/_____/_____ , in lieu of my signature, due to special circumstances. I will provide my legal signature to this document, upon my first availability. _____ Initials of Life Management Associates, LLC, Representative.

_____ _____/_____/_____

Client Signature(s) Date

_____ _____/_____/_____

Client Signature(s) Date

_____ _____/_____/_____

Parent/Legal Guardian Signature (Mandatory If Client Is A Minor) Date

_____ _____/_____/_____

Representative of Life Management Associates, LLC Date