Staltaro Psychological Services

To arrange for a Telehealth Visit, please call 860-502-4908 at least 48 hours in advance of your appointment to coordinate it with your clinician. If you have already done so, this information provides information regarding what you should expect and how to connect with your provider at the time of your appointment.

We recommend that you use any apple or android phone, tablet or laptop. If you use a desktop computer instead, then you'll need a webcam and microphone attached.

Prior to your first telehealth session you are required to review and sign and return the attached informed consent form and credit card agreement. You can return the form by email, fax to 860-513-4828, or print and mail to 96 Connecticut Blvd, East Hartford, CT 06108. If you would like a paper copy of this form mailed to you please call 860-502-4908 to request it.

A few minutes before your scheduled appointment please establish the video connection by clicking this link selecting your provider: http://www.staltaro.com/Telehealth/

If you have any questions, concerns or need to change your appointment please call us at **860-502-4908** as soon as possible A $50 late cancellation or no show fee may apply for visits cancelled without sufficient notice.

Staltaro Psychological Services

Consent to Participate in Telehealth Consultation

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider. I understand that if I am in crisis and require immediate assistance, I will contact 911 or 211 or visit my nearest emergency room immediately.

I understand that a variety of alternative methods of mental healthcare including in-person services may be available to me and that I may choose one or more of these at any time. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

I hereby consent to Staltaro Psychological Services LLC providing health care services to me via telemedicine. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit. As always, your insurance carrier will have access to your medical records for quality review/audit.

I am aware that there are potential risks to the use of telehealth. Examples include: 1.) Information may not be sufficiently transmitted, (poor video or audio transmission) to allow for appropriate clinical decision making. 2.) Technical malfunctions may cause delays in care, 3.) There may occur failures of security protocols that can result in a breach privacy of personal medical information. 4.) In rare cases lack of access to complete medical records can result in clinical judgment errors. 5.) Emergency protocols, emergency services and crisis resolution via remote services are limited.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Staltaro Psychological Services LLC, Perry Staltaro, at 96 Connecticut Blvd, East Hartford, CT 06108 (860) 502-4908. As long as this consent is in force (has not been revoked) Staltaro Psychological Services may provider health care services to me via telemedicine without the need for me to sign another consent form.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- **I am aware that if I am in crisis and need urgent assistance, I will not rely on telehealth conferencing, I will contact 911 or 211 immediately or go straight to my nearest emergency room.**
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____

Patient's/parent/guardian signature **Date**

Staltaro Psychological Services

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled. If you have **Medicaid/husky insurance,** do not fill out this form.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____ 3 digit (4 for amex) CID Code: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I authorize Staltaro Psychological Services LLC to charge my credit card above for agreed upon services. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Staltaro Psychological Services (SPS) in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of a chargeback or an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that SPS may at its discretion attempt to process the charge again within 30 days, and agree to an additional $55 charge for each chargeback or attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.