Metropolitan Counseling Associates, LLC

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Informed Consent for Electronic Invoicing and Teletherapy Services

Electronic Invoicing

As of February 2020, MCA has started to send monthly invoices electronically through our encrypted, HIPPAA compliant email system. Please provide in the space below the email address you wish the invoice to be sent to:

_____
(email address)

_____
Patient Name

Please return this form via fax (301-654-7770), email (office@metcounseling.com) or mail it to our office at 7201 Wisconsin Ave, Suite 700, Bethesda, MD 20814.

If you prefer not to receive your invoice electronically, you can request a printed copy in writing or in person from our front office. Please note that this system will fully replace our current practice of mailing invoices and invoices will no longer be mailed from our office on a routine basis. Please also note that invoices will be sent from an unmonitored mailbox. If you need to discuss your bill or have difficulty opening the encrypted e-mail, please direct correspondence to *office@metcounseling.com.*

Teletherapy Services

In accordance with Title 10 of the Maryland Department of Health and Maryland Board of Social Work, "Teletherapy" services pertain to interactive audio, video or other telecommunication or electronic media used to provide psychotherapy at a location other than the geographic location of the client. "Teletherapy" does not apply to audio only telephone conversation, electronic mail, facsimile transmission and text messaging.

Metropolitan Counseling Associates therapists provide teletherapy through private and secure connections that comply with federal and state laws. In the case of any breach of data, clients will be notified as quickly as possible. All teletherapy services will be held to the same standards of practice and documentation as in-person sessions.

Clients participating in teletherapy are required to identify and provide a local provider in the state you are currently residing (i.e. Psychiatrist, hospital) for emergency services. The following provider serves as a local emergency contact.

Name of Provider _____

Address _____

Phone Number _____

Email (optional) _____

The below signature is my informed consent and authorization for teletherapy services with

_____ and Metropolitan Counseling Associates.
(Clinician's Name)

I understand that I can revoke this authorization at any time, and that revoking authorization only pertains to present and future services. I also understand that privacy and security of the teletherapy connection in my location is my responsibility. Any breaches of data related to my technology is not the responsibility of Metropolitan Counseling Associates.

_____ _____
Signature (Patient) Date

_____ _____
Signature of Parent or Legal Guardian (if under 18) Date