**Authorization & Statement of Understanding**

Skype & Other Audio/Visual Sessions

**Client Information**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (Work)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Home)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Cell)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize the North Suburban Center for Anxiety, LLC and its associates to use Skype and all other forms of telecommunication as a means for psychotherapy. I understand that Skype and other forms of telecommunication do not meet the standards set forth by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and that there is a greater risk to privacy than with traditional psychotherapy. 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 that the North Suburban Center for Anxiety, LLC has already taken action in reliance on it. I may specify the date, event, or condition on which this consent expires.

This authorization expires on \_\_\_/\_\_\_/\_\_\_\_\_\_.

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Client’s signature (age 12 and older) Date

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Parent/guardian of minor Date

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Witness signature Date