SIMPLY THRIVE THERAPEUTIC ASSOCIATES, PLLC

Consent & Statement of Understanding: Audio/Visual Sessions

Client Information

Name _____ Date of Birth_____

Home address_____ Zip_____

Phone: (Work) _____(Home) _____ (Cell) _____

I hereby authorize Simply Thrive Therapeutic Associates to use Doxy.me as a means for psychotherapy. Doxy.me is a HIPAA compliant platform 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 Simply Thrive Therapeutic 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

1200 SE Maynard Rd Suite 103 Cary NC 27511
Office (919)636-0762 Fax (919) 826-9314
www.tinawinemillertherapy.com