Lori A. Jensen, Ph.D.
Jensen Consulting Group
330 E. Main St., Suite 201, Barrington, IL 60010
135 N. Greenleaf, Suite 228, Gurnee, IL 60031

Consent to Treatment

I, voluntarily, agree to receive psychological assessment, treatment, or counseling services, and authorize Dr. Lori Jensen, the undersigned psychologist, to provide such psychological assessment, treatment, or counseling services as are considered necessary and advisable. I understand that all information will be treated as confidential in accordance with state laws.

The goal of these psychological services is to help me achieve the highest possible level of daily function and enhance overall quality of life. I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through Dr. Jensen at any time.

Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. I understand that my insurance policy is a contract between me and my insurance company and that Dr. Jensen is not a party to that contract. As such, I understand that I will be responsible for payment for services, regardless of any insurance company's arbitrary determination of usual and customary rates.

Assignment of Insurance Benefits: I understand that payment for Dr. Lori Jensen's services will be made either privately or through my healthcare insurance. Dr. Jensen may agree to accept assignment of primary and secondary insurance benefits (if applicable). I am aware that Dr. Jensen cannot bill my insurance company unless I give her my insurance information and a signed consent form.

By signing this consent form, I assign payment directly to Dr. Lori Jensen all insurance benefits otherwise payable to me for psychological services provided by Dr. Jensen. I understand that filing insurance claims is not a guarantee of payment and that I am financially responsible for charges (including unpaid copayments or deductible amounts) not paid by this assignment. This assignment of benefits is irrevocable.

Medicare Patients: Dr. Jensen agrees to accept Medicare assignment for payment in full of her services. She will not charge me, personally, for any fees over and above what Medicare allows for her services as determined by Federal Law. I request that payment of authorized Medicare benefits be made on my behalf to Dr. Lori Jensen for any services provided to me by Dr. Jensen. I authorize any holder of medical information on me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Missed appointments: Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

By signing this Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____ _____

Client Signature Date

_____ _____

Provider's Signature Date

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Telehealth Informed Consent

I understand that telehealth or teletherapy involves 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; and hereby consent to receiving health care services to me via telehealth over secure video conferencing platform.

I understand that the laws that protect privacy and the confidentiality of my medical information also apply to telehealth or teletherapy.

I understand that while telehealth or teletherapy treatment has been found to be effective in treating a wide range of disorders, there is no guarantee that all treatment of all clients will be effective.

I understand that there are potential risks involving technology, including but not limited to: Internet interruptions, and technical difficulties. I understand that technical difficulties with hardware, software, and internet connection may result in service interruption and that the health care provider is not responsible for any technical problems and does not guarantee that services will be available or work as expected.

I understand that I am responsible for information security on my computer and in my own physical location. I understand that I am responsible for creating and maintaining my user name and password and not share these with another person. I understand that I am responsible to ensure privacy at my own location by being in a private location so other individuals cannot hear my conversation.

I understand that my health care provider or I can discontinue the telehealth/teletherapy services if it is felt that this type of service delivery does not benefit my needs.

I have read and understand the information provided above regarding telehealth or teletherapy, have discussed it with my health care provider and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth or teletherapy in my care.

Signature _____

Date_____