**Distance Counseling Informed Consent Agreement**

Client Service File # \_\_\_\_\_\_\_\_

I,       (client’s name) hereby consent to engage in voice-over-Internet Protocol (voIP) video-based therapy (hereby referred to as distance counseling) with a TELL Counseling therapist as the main modality for my psychotherapy treatment. TELL only offers English language professional video counseling when it is not possible to see a face to face professional, for example when none are available in the geographic area that provide therapy in English.

I understand the following with respect to distance counseling:

1. I understand that there are risks and consequences associated with voIP video-based counseling. These may include, but are not limited to, the possibility of technical disruptions during sessions, and that video technology can be subject to outside interference.
2. I understand that I may benefit from video-based counseling, but results cannot be guaranteed or assured. I understand that video-based services and care may not yield the same results or be as effective as face-to-face service, and that outcomes research regarding validated video counseling is still in its infancy.

Client’s Initial:

**1. Confidentiality**

All psychotherapists working at TELL Counseling are governed by the ethical and professional guidelines regarding confidentiality applicable to their professional membership (e.g. American Psychological Association, National Association of Social Workers).

All information is kept strictly confidential within the clinic. We do not share information with others unless you (the client) have given us written permission to do so. In this case, we will have to obtain your consent via a ‘release of information’ consent form. We do not share information with TELL Lifeline. They do not share information with us.

In the exceptional case that you are in danger of harming yourself or others and/or being harmed, the rule of confidentiality will be over-ridden. In this case we might disclose confidential information to the appropriate person/authority to protect you or others.

Client files are stored in a secure location and are accessible only by staff of this clinic.

Client’s Initial:

**2. Appointment Cancellation Policy**

Please provide 24 hours advance notice if you are unable to attend a scheduled appointment. If you fail to do so, you will be charged the full fee amount for the missed session and expected to pay before the next session.

To cancel an appointment, please call **03-4550-1146** and leave a message.

Client’s Initial:

**3. Fees**

Services are billed according to a flexible fee scale based on household income and resources. Please provide a proof of household income (before tax). Subsidized counseling is available for those who qualify for a reasonable number of sessions and is subject to review by the Clinical Director. If your financial situation changes, please notify your psychotherapist. Session fees are based on a 50 minute session.

Occasionally, your therapist may need to spend additional time regarding your care outside of the therapy session in the form of telephone calls, emails, or with written permission, obtaining collateral information or report writing. If this time is substantial, the therapist may charge you for time spent based upon a pro-rated basis of your session fee.

For distance counseling, the fee is only payable by credit card or bank wire transfer. TELL requires credit card details and authorization to charge the credit card for services rendered. Payments can also be made by bank or postal transfer in preference to credit card, however TELL will still require your credit card details.

Payment for each distance counseling session is made in advance of the session. In the instance that the bill remains unpaid, TELL will charge your credit card. By signing this document, you authorize TELL to do so.

A 10% consumption tax is inclusive in the session fee shown below.

**Session Fee (tax inclusive): ¥** \_\_\_\_\_\_\_\_\_\_ **per 50 min. session.**

**In case for payments by Credit Card/PayPal, Amount Charged (tax & service charge inclusive): ¥**\_\_\_\_\_\_\_\_\_ **per 50 min. session**

Client’s Initial:

**4. Quality of Service**

If you have a complaint concerning treatment received, you can register your complaint with the Clinical Director or Chairman of the Board.

Client’s Initial:

**Your signature below indicates that you have read and understood the above information and agree to the conditions.**

Signature of Client/Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Signature of Psychotherapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit Card Details \*\*\*REQUIRED\*\*\***

**Card Type:** **[ ]  Visa** **[ ]  MasterCard** **[ ]  American Express** **[ ]  JCB** **[ ]  UFJ**

**Card Number:**

**Exact name on card:**

**Expiry Date (mm/yy):**    **/**

**Credit Card Security Code** (for validation purposes):

**Amount Charged** (consumption tax & service charge incl.) **¥**\_\_\_\_\_\_\_\_\_ per 50 min. session

This information will be contained within your confidential client file and destroyed at the termination of your telephone counseling sessions.

I authorize TELL to use this credit card for Distance counseling charges in the event other payment methods have not been used. I have read and understand the information provided above, which has also been explained to me verbally. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: