J. DAVID COLLINS & ASSOCIATES LLC
Addictions & Mental Health

Patient Release and Agreement

Client Name: _____ **DOB:** _____

Cell Phone: _____ **Email:** _____

Please initial the following:

_____ I agree to receive communication from JDCA via text

_____ I agree to receive communication via Email from JDCA

JDCA will be providing Telehealth services utilizing a HIPAA compliant telehealth platform. The service requires that the patient have access to a computer or device with video capability and an internet connection. If the patient does not have access to a device with an internet connection, JDCA will have stations set-up at the office to provide patients the ability to access care.

YES NO I have a digital device with video capability & internet connection

_____ Initial — If, No - I will come to the office to access an internet connection continue care

I agree to engage in telehealth services with JDCA.

_____
Printed Client Name

_____ _____
Client Signature **Date**

Training information on how to access and utilize the telehealth portal will be provided. We will have a resource available to assist with training and any issues that you may have using the portal.