TELETHERAPY / TELEMEDICINE CONSENT FORM (REQUIRED IN THE EVENT TELEHEALTH IS NECESSARY)

Definition of services:

I, _____, hereby consent to engage in Teletherapy/ Telemedicine technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video or data communications. I also understand that Telehealth involves the communication of my medical/ mental health information, both orally and/or visually. Telehealth has the same purpose or intention as Psychotherapy or Psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that Teletherapy/ Telemedicine may be experienced somewhat differently than face- to - face treatment sessions.

I understand that I have the following rights with respect to Teletherapy/ Telemedicine: Clients Rights, Risks, and Responsibilities:

1.I, the client need to be a resident of Pennsylvania (this is a legal requirement for PhD, PsyD, LCSW, LMFT, MD, RNC and LPC practicing in this state under a PA license.)

2.I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

3.The laws that protect the confidentiality of my medical information also apply to Teletherapy/ Telemedicine. As such, I understand that the information disclosed by me during the course of my therapy, treatment or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I received at the start of my treatment with _____.

4.I understand that there are risks and consequences of participating in Teletherapy/ Telemedicine, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my provider, that :the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

5.There is a risk that services could be disrupted or distorted by unforeseen technical problems.

Client Signature: _____ Date: _____

In Case of an Emergency

Emergency Procedures Specific to Telehealth Services

There are additional procedures that we need to have in place specific to Telehealth services. These are for your safety in case of an emergency and are as follows:

You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and Telehealth services are not appropriate.
I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life -threatening emergency only. Please enter this person's name and contact information below.

Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees to take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

Please list your ECP here:

Name: _____

Phone: _____

You agree to inform me of the address where you are located at the start of every session. You agree to inform me of the nearest Mental Health hospital to your primary location that you prefer to go to in the event of an emergency.

Hospital: _____

Phone: _____