

DZ Counseling & Neurofeedback Training Services

Child, Adolescent, Adult, Couples & Family Counseling

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Consent For Telehealth Appointment

1. I understand that my health care provider wishes me to engage in a telehealth appointment.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such an appointment will not be the same as a direct client/health care provider visit since I will not be in the same room as my provider.
3. I understand that a telehealth session has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my provider or I can discontinue the telehealth session if it is felt that the video conferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered and the risks, benefits and any practical alternative have been discussed with me in a language in which I understand.

Consent to Use the Telehealth by SimplePractice Service

Telehealth by SimplePractice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by SimplePractice Service facilitates video conferencing and is not responsive for the delivery of any healthcare, medical advice, or care.
4. I do not assume that my provider has access to any or all the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up to date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given a chance to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client's Name

Date

Client's Signature (14 yrs. and older)

If a client is under the age of 18, Parent's/Legal Guardian's must sign:

I represent that I am a parent or legal guardian of the child identified in this form. I represent that I have full or shared legal authority to consent to the child's treatment and that the consent of no other person is required.

Parent's/Legal Guardian's Name

Date

Parent's/Legal Guardian's Signature

Parent's/Legal Guardian's Name

Date

Parent's/Legal Guardian's Signature