Insight Professional Counseling, LLC
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INFORMED CONSENT FOR TELEHEALTH CONSULTATION THERAPY SERVICES

This document uses the words 'I' and 'me' to represent adult clients and minor children.
I understand that my health care provider has offered a telehealth consultation therapy service due to COVID-19 concerns or other issues meeting criteria to support virtual session visits.

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

CONSENT TO USE A TELEHEALTH Virtual Visit SERVICE
Telehealth by Zoom or TherapyAppointment 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 virtual visits are 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 Zoom, TherapyAppointment nor any Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by TherapyAppointment Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by Zoom or TherapyAppointment 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 Services.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment, and I will make sure I have privacy in my own location.

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 ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Client's signature: _____ Date: ____/____/_____

Parent/guardian signature: _____ Date: ____/____/_____