Consent for Telehealth Consultation

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my healthcare provider wishes me to engage in a telehealth consultation.
2. I understand that the video conferencing technology may affect my treatment. For example, all appointments would not be the same as a direct client/healthcare provider visit since I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits, including more accessible access to care and the convenience of meeting from a location of my choosing.
4. I understand this technology has potential risks, including interruptions, unauthorized access, and technical difficulties. I know that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing 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 alternatives have been discussed with me in a language that I understand.
6. I moreover understand that if these services are for anyone under the age of 18 years, and especially under the age of 12 years, the appropriateness and efficiency of telehealth services will be determined based on the needs of the individual, the area(s) being addressed in therapy and must be authorized by the Clinical Director.
7. I understand that telehealth is not an option at any time if there is an intensive need for services in situations where I (as the client) or my child (as the client) have disruptive behaviors (e.g., are distracted, not participating in therapy, etc.), suicidal ideations, suicidal plans, or active self-harming behaviors.
8. I understand that if my provider determines that telehealth is not appropriate for my treatment progress for any reason, they will let me know and provide alternative options for appointments.

CONSENT TO USE THE TELEHEALTH BY PRACTICE SERVICE

Telehealth by SimplePractice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use, and no passwords are 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 emergency or urgent medical services.
3. The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for delivering 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 SimplePractice Service – or that such information is current, accurate, or up-to-date. I will not rely on my health care provider to have 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.
- I fully understand its contents, including the risks and benefits of the procedure(s).
- I have been given ample opportunity to ask questions, and any questions have been answered satisfactorily.

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

Client Printed Name

Client/Parent Guardian Signature

Date