Melinda Kaserman, LCPC
500 W. Idaho Street Suite 204, Boise, Idaho 83702
(208) 440-5464

CONSENT FOR TELEHEALTH CONSULTATION

I consent to participate in Electronic Counseling Services or Telehealth, with Melinda Kaserman, LCPC. I understand that Telehealth is the use of HIPAA compliant electronic information and communication technologies (video and audio technology) by a mental health provider to deliver services to a client in a different location than the mental health provider.

I understand the following with respect to Electronic Counseling Services:

1. I understand that my provider and I have discussed Telehealth and wish to engage in a telehealth consultation.
2. 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.
3. 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 in the state of Idaho only. By signing this form, I also understand that results of any therapy, whether in person or through Electronic Counseling Services, cannot be guaranteed.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. Additionally, third-party services that feature text messaging or other direct electronic messaging may provide limited security and protection of confidential information. As well as a limited ability to respond to emergencies.
5. 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. And/or a higher level of care is required due to psychosis, crisis, suicidal thoughts, homicidal thoughts.
6. I understand that there will be no recording of any of the online sessions or face to face sessions. Confidentiality applies to what is shared in session and documentation about the sessions. Disclosure is only permitted with written consent and when required by law.
7. I understand that Electronic Counseling Service appointments need to be conducted in a private and confidential space. I agree (unless otherwise agreed upon) to conduct my appointments in a private and secure room where I am the only one present. I will be prepared to do a “room scan” to ensure that I am the only one present in the room.
8. I understand that if a disruption or an emergency situation occur, my therapist Melinda Kaserman can be contacted at (208) 440-5464. If a disruption occurs and I am unable to reconnect, Melinda Kaserman will contact me via phone call to re-schedule the appointment should we not be able to resolve the disruption within 10 minutes.
9. I understand that if there is an emergency my therapist will need to contact my emergency contact and/or appropriate authorities.
10. 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 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 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 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 ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Signature Date

_____

Printed Name