GODMAN PSYCHOLOGICAL SERVICES, P.C.
Helping to navigate the mind
4231 Balboa Avenue #1256
San Diego, CA 92117
T: (619) 785-3665
info@godmanpsych.com

CONSENT FOR PSYCHOLOGICAL SERVICES PROVIDED VIA TELEHEALTH

1. I understand that a licensed or registered health care provider at Godman Psychological Services, PC wishes me to engage in services provided via telehealth. The health care providers include:

   Carolyn Godman, Ph.D., CCHP-MH CA PSY28831/NYS 019200/FL TPPY2883

2. I understand that the laws that protect privacy and the confidentiality of client information also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.
3. I understand that telemental health is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet based communication is not 100 % guaranteed to be secure.
4. I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.
5. I understand that I or my therapist may discontinue the telemental sessions at any time if it is felt that the video technology is not adequate for the situation.
6. I understand that if there is an emergency during a telemental health session, then my therapist may call emergency services and/or my emergency contact.
7. I will not record any telehealth sessions without written consent from my health care provider. I understand that my health care provider will not record any of our telehealth sessions without my written consent.
8. My health care provider explained to me how the video conferencing technology that will be used to effect 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.
9. I understand that I will be asked to state my full name and address of my present location at the beginning of each telehealth session and that I must be physically located in the state my clinician is licensed in during my telehealth visit.

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10. I will inform my provider if any other person can hear or see any part of our session before the session begins, for example, if a friend or family member is in the room.
11. 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.
12. I understand there are potential risks and limitations of receiving treatment via telehealth, including, but not limited to, delays in evaluation and treatment due to problems or failures of equipment and technology, such as internet connection problems, computer or mobile phone problems, and other technological problems. In very rare events, security protocols could fail, causing a breach of privacy of personal medical information, and persons may overhear you in your location, or the provider, which could cause privacy concerns. I agree to hold harmless Godman Psychological Services, PC, and my health care provider for delays in evaluation, for information lost, or breach in privacy due to said risks and/or technical failures.
13. I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to telemental health services.
14. I understand a “no show” or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment. I understand credit card or other form of payment will be established before the first session.
15. I understand I will be responsible for any copayments or coinsurance that apply to my telehealth visit.
16. I understand my therapist will advise me about what telemental health platform to use and she will establish a video conference session.
17. 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.

<u>CONSENT TO USE THE TELEHEALTH BY DOXY.ME</u>

Telehealth by DOXY.ME is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple and secure to use. By signing this document, I acknowledge:

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1. Telehealth by DOXY.ME 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 DOXY.ME nor your therapist provide any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. Telehealth by DOXY.ME 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 DOXY.ME services – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to provide me any of this information regarding the telehealth by DOXY.ME services.
5. I agree to hold harmless Godman Psychological Services, PC, and my health care provider for any technical issues experienced from the use of Telehealth by DOXY.ME.

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CONSENT FOR PSYCHOLOGICAL SERVICES PROVIDED VIA TELEHEALTH

BY SIGNING BELOW I AM AGREEING THAT:

·I have read and understood, or had this form read and/or had this form explained to me and understand its content.

·I fully understand its contents including the risks and benefits of the procedure(s).

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

·I consent to the use of telehealth/telemedicine if the clinician determines that the benefit or service is clinically appropriate to be provided.

CLIENT NAME: _____ CLIENT DOB: _____

Signature of Client:_____ Date:_____

Signature of Parent/Guardian:_____ Date:_____

Relationship to Client:_____

Clinician Name: _____