



Haven Counseling

Consent to Participate in a Telehealth Session

1. I understand that my health care provider, Amanda Plumb LPC with Haven Counseling wishes me to engage in a telehealth session.
2. My health care provider has explained to me how utilize www.Doxy.Me the HIPAA compliant medical platform. This video conferencing technology will be used to affect such a consultation which will not be the same as a “traditional face to face direct patient/health care provider visit” due to the fact that I will not be in the same physical office room as my health care provider. I understand it is important for me to be in a quiet, private space that is free of distractions during the session. I understand my health care provider will be using password protected and secure Wi-fi internet.
3. I understand there are potential risks to this technology including: interruptions, unauthorized access, and technical connection difficulties. It is important for you to use a secure internet connection rather than public/free Wi-Fi. I understand that my health care provider or myself can discontinue the telehealth appt. if it is felt that the videoconferencing connections are not adequate for the situation. A telephone number where you can be reached will be needed in the event the session needs to restart due to a technical problem.
4. I have been informed of the alternatives to a telehealth session explained to me, and I am choosing to participate in a telehealth session.
5. In a crisis, I understand that the health care provider requires a safety plan that includes at least one emergency contact and the closest ER to my location. The health care provider’s responsibility will conclude upon the termination of the video conference connection.
6. I understand that billing will occur from my practitioner which is customary for receiving psychotherapy services.
7. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this telehealth consultation. 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.

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 telehealth consultation • That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Patient’s Printed Name

Patient’s Signature

Date

If the patient is under 18, Parent Signature is required

Date