Lisa Grossman, DOM, AP, LCSW 941-779-7443

3645 Cortez Road West, Suite 110 alchemyacu@gmail.com

Bradenton, FL. 34210 alchemyacutherapy.com

Telehealth Disclosure

Telehealth (TH) Informed Consent

I ______________________________ hereby consent to engage in telehealth therapy (includes synchronous and asynchronous forms of communication) with Lisa Grossman, DOM, AP, LCSW as the main form of my psychotherapy treatment. I understand that telehealth includes the practice of health care including mental health delivery, diagnosis, consultation, treatment and education using HIPPA compliant interactive audio and video.

I understand that I have the following rights with respect to Telehealth:

(1) I have the right to refuse TH at any time without affecting my right to future care or treatment.

(2) The laws that protect the confidentiality of my medical information also apply to telehealth and that the information disclosed by me in therapy is confidential with exception of the mandatory reporting laws that include but are not limited to: child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim and imminent risk of harm to myself.

(3) I understand that the dissemination of any personally identifiable images or information from our telehealth interaction shall not occur without my written consent.

(4) I understand that TH sessions are not being recorded, and separate written approval and consent is needed in order to videotape a session.

(5) I understand that there are risks from TH that may include but are not limited to: the possibility despite all reasonable efforts by my provider, the transmission of medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/ or misunderstandings may occur more easily, particularly when care is delivered in an asynchronous manner. I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telehealth.

(6) I also understand that while there is an empirical evidence base supporting the efficacy of TH, it may not yield the same results as face to face services. I understand that if my provider believes that I would be better served by another form of therapeutic service (such as face to face) I will be referred to a therapist in my area who can provide such a service.

(7) I understand that my contact information and contact information for my emergency contact will be available at every session and give consent to contact my emergency contact if deemed necessary. In the case of client in high crisis requiring high level of support, telehealth may not be sufficient. In those

circumstances it may be important that we address a potential crisis situation plan and/or dial 911. Then, call me back after you have called or obtained emergency services.

(8) I understand that in the event of technical failure, I will provide a phone number for follow up contact if a plan for technical failures has not already been arranged with my provider. If technical failure arises and we are unable to resume the connection, please call me back at the following phone number: 941-779-7443.

(9) I understand that any form of psychotherapeutic service carries risks and benefits and that despite my efforts and my providers efforts, my condition may not improve and in some cases may worsen.

(10) I understand that results from telehealth cannot be guaranteed or assured. The benefits of telehealth may include but are not limited to: an increased ability to express thoughts and feelings, transportation and travel barriers are reduced, and time constraints are minimized.

(11) I understand that I have access to my medical information and copies of medical records in accordance with Florida laws.

(12) I understand that it is my responsibility to call my insurance company before I begin TH sessions to determine if the psychotherapy fee is covered by my insurance. I understand that telehealth services may not be covered by insurance and that I may be responsible for any fees incurred during psychotherapy which incorporates TH. The same fee rates apply for telehealth as apply for in-person therapy.

(13) Risks of Confidentiality: because telehealth sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end, I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted.

I use a telehealth platform called doxy.me which is HIPAA compliant and offers the highest level of encryption and protection. At our scheduled telehealth appointment time, log on to https://doxy.me/drlisagrossman and I will establish a video conference telehealth session. I also use Zoom cloud meeting platform.

I understand that I may revoke this authorization at any time by giving my written notice. I may specify the date, event or condition on which this consent expires. If none is stated, and if no prior notice of revocation is received, this consent will expire one year after the date it was initiated. This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any terms of that agreement. Your signature below indicates agreement with its terms and conditions.

Name____ Date________________

Signature____