Your Song Counseling

INFORMED CONSENT FOR TELEMEDICINE SERVICES

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when the individual is located at a different site than the provider; and hereby consent to Your Song Counseling providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine.

I hereby authorize Your Song Counseling to use any HIPAA-compliant platform as a means for providing psychotherapy remotely.

I understand that if I am located outside of the State of Washington, the counseling services you are allowed to provide to me may be limited or prohibited. If I am located outside of the State of Washington, I will explore other options with Your Song Counseling.

I understand that telemedicine is not appropriate for all clients and all situations. If I or Your Song Counseling determines that telemedicine is not appropriate for me, I will receive assistance from Your Song Counseling to obtain face-to-face counseling.

I understand that successful use of distance counseling services requires a reasonable level of access to computer hardware and software. If I do not have access to such resources, I and Your Song Counseling will discuss available alternatives.

I understand that at times it may become necessary for Your Song Counseling to allow access to their computer hardware and software for purposes of system maintenance, repair, upgrades, or other similar purposes. In such cases, Your Song Counseling will make reasonable efforts to protect my confidential information.

In understand that in case of hardware, software or other system failure, Your Song Counseling can reach me by phone to coordinate our continued work together.

At the initiation of our therapeutic relationship I will share or receive the following information:

- My physical location and address;
- My local hospital emergency room phone number;
- My local crisis line phone number.

I further attest that since I have chosen this form of communication, I have been advised that it may not be covered by my insurance company and that I am responsible for any fees incurred during psychotherapy which incorporates telecommunication.

I understand that I may revoke this authorization at any time by giving written notice, except to the extent Your Song Counseling has already taken action in reliance on it. 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.

By signing this document, you are attesting that you have received, read, fully understand and consent to the disclosures, terms, and conditions above and that you are requesting to participate in technology assisted counseling services/teletherapy/telehealth provided through Your Song Counseling.

I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature Date