**Consent for Telehealth Psychotherapy Sessions:**

1. My health care provider and I wish to engage in telehealth services.
2. I understand that I will not be in the same room as my health care provider, and has explained to me how the video conferencing technology works
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.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider may have limited ability to see and interpret non-verbal cues such as facial expressions and posture.
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.
6. 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.
7. I agree not to record any session without written consent of my health care provider, and I agree to inform my health care provider if I will be outside the state of Oregon at the time of our scheduled session as we may have to re-schedule. I further agree to inform my health care provider if anyone else is in the room with me or can overhear our conversations.

**Consent to use the Telehealth by Zoom Service:**

Telehealth by Zoom 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 Zoom 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 Zoom 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 Zoom 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 Zoom 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 Zoom 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.

**By signing below, I acknowledge that I have read, understood, and agree to the items contained in this document.**

Patient signature Date