Shannon Sorini, LCSW
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TELEHEALTH DISCLOSURE

Telemedicine/TeleHealth Informed Consent

I _____ hereby consent for my minor child _____ to engage in telemedicine (e.g., internet, email or telephone based therapy) with Shannon Sorini as an optional mode of my psychotherapy treatment. I understand that telemedicine/TeleHealth includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to other health care practitioners.

I understand that I have the following rights with respect to telemedicine/TeleHealth:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine/TeleHealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

I also understand that the dissemination to researchers or other entities, of any personally identifiable images or information from the telemedicine interaction shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine/TeleHealth . These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my 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 can more easily occur, especially when care is delivered in an asynchronous manner.

In addition, I understand that telemedicine/TeleHealth -based services and care may not yield the same results nor be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I will be referred to a psychotherapist in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy and that, despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine/TeleHealth, but results cannot be guaranteed or assured. The benefits of telemedicine/TeleHealth may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

(5) I understand that I have the right to access my medical information and copies of medical records in accordance with the law, that these services may not be covered by insurance, and that, if there is intentional misrepresentation, therapy will be terminated.

(6) As a courtesy Shannon Sorini will bill your insurance company, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay or the entire hourly fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover telemedicine/TeleHealth, we request that you pay the balance due at that time. In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Shannon Sorini, LCSW. Please note any out of office contact will be billed at the hourly rate and are not reimbursable by your insurance company.

(7) I understand if it is my responsibility to know my insurance coverage of telemedicine/TeleHealth and that any services will be paid in full by me to Shannon Sorini for any non-covered telemedicine/TeleHealth services.

I have read and understand the information provided above. I understand this information given to me from my therapist and all of my questions have been answered to my satisfaction.

Name _____ Date _____

Client Signature: _____

Minor Client: _____

If over age of 14

Email for Teleheath: _____