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TELEHEALTH CONSENT FORM

Patient's Name: _____

Date of Birth: _____
(mm/dd/yyyy)

1. I understand that my therapist wishes me to engage in telehealth consultation

2. My therapist has explained to me that the video conferencing technology that will be used will affect such a consultation which will not be the same as an in person visit due to the fact that I will not be in the same room as my therapist.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my therapist or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. I further understand that I will have the right to request to terminate the consultation at any time.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

5. I have had the alternatives to a telehealth consultation explained to me, and I am choosing to participate in a telehealth psychotherapy.

6. I understand that the responsibility of the telehealth consulting specialist will conclude upon the termination of the video conference connection.

7. I have had a direct conversation with my therapist, 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.

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

_____ _____

Patient Signature ***Date (mm/dd/yyyy)***