Ellen A. Begley, Ph.D., PLLC

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CONSENT TO THE USE OF TELEHEALTH IN TREATMENT

Client's name ____________________________________ Date of birth ______________

Email address ____

1. I understand that my psychotherapist is offering me the opportunity to engage in telehealth (video conferencing).
2. I understand that there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that either my psychotherapist or I can discontinue the telehealth session if either of us concludes that the video-conferencing connections are not adequate for the situation.
3. I understand that the laws that protect privacy and confidentiality also apply to telehealth, and that the encrypted internet platform to be used for telehealth is HIPAA-compliant. Also, at the end of each session, it destroys all records specific to the individual client.
4. I understand that limited information may be shared with other individuals for billing purposes, just as with in-person sessions. The usual HIPAA regulations for confidentiality apply.
5. I understand that I need to conirm with my insurance company that the video sessions will be reimbursed: if they are not covered, you will be responsible for full payment.

Important information:
--You need to use a webcam or smartphone during the session.
--It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
--It is important to use a secure internet connection rather than public/free Wi-Fi.
--It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the therapist in advance by phone or email.
--We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.

I hereby authorize Ellen A. Begley, Ph.D., to use telehealth in the course of my treatment

Signature of client (or person authorized to sign for client):

____ Date: _________________

Provider signature:

____ Date: _________________