TELEHEALTH CONSENT

By signing below, you hereby consent to receive, or have your child receive, therapy services from me via telehealth. "Telehealth" includes the practice of health care delivery, diagnosis, and treatment consultation using interactive video, audio, and/or data communications.

There are benefits and risks to telehealth. The benefits of telehealth include convenience and continuity of care in times when you are unable to see me in-person. Risks include the risks inherent in transmitting information electronically that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. In the event of a technological failure during a telehealth visit, you agree that I may contact you at the phone number listed below.

It is your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear our communications or have access to the telehealth technology. To further ensure the confidentiality and security of our communications, you are not permitted to record telehealth appointments.

All fees for telehealth services are the same as for non-telehealth services. You are financially responsible for all services rendered and for the charges associated with late cancellations and missed appointments, where such charges are permitted.

I may determine at some point during my treatment of you that treatment via telehealth is no longer appropriate. If this happens, we will discuss options for in-person care or referrals to other practitioners.

Patient Name:

Patient Date of Birth:

* If patient is under the age of 18 the patient's parent or legal guardian must sign below unless a minor patient is requesting to be assessed as a mature minor in accordance with state eligibility guidelines

Signed: ____

Name: ____

Relationship to Patient (e.g., self, parent):

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