Consent for Telehealth Therapy Sessions

In the case where we are unable to meet face-to-face, do you consent to engaging in contacts by phone or video or email (telemedicine) with me as part of your psychotherapy?

 o YES         o  NO

In the case where we elect not to meet face-to-face, I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby consent to engage in contacts by phone or video or email (telemedicine) with Dr. Saatchi as part of my psychotherapy. I understand that “telemedicine” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

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

1)       I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2)       The laws that protect the confidentiality of my medical information also apply to telemedicine. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to the situations listed in the original consent form which pertain to safety.

3)       I understand that there are risks and consequences from telemedicine, including but 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; and/or the electronic storage of my medical information could be accessed by unauthorized persons.  In addition, I understand that telemedicine-based services and care may not 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 services (e.g., face-to-face service) I will be referred to a psychotherapist who can provide such services in my physical location, if possible.

4)       I understand that I may benefit from telemedicine, but results cannot be guaranteed.

5)       I understand my insurance may not cover telehealth services and I am responsible financially.

I have read and understand the information provided above. I have discussed it with my psychotherapist and all of my questions have been answered to my satisfaction.

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Client Signature/Date

If client is a minor: Please sign above and print child’s name and date of birth below:

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Child Name/Date of Birth