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CONSENT FOR TELEHEALTH CONSULTATION

Telehealth is a form of therapy that enables us to communicate through technology. E-mail communication, video conferencing, Facetime, phone sessions and phone calls, and text messages all constitute "Telehealth" in the State of New Jersey, New York, and Illinois. I ask that you please fill out this form in the event that you choose to do sessions via video counseling and so that we may communicate through electronic communications.

1. I understand that my health care provider wishes me to engage in a Telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a Telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the Telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, 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.
6. I understand that not all insurance companies will cover Telehealth services and that I may be fully responsible for the cost of sessions.
7. You agree to inform me of the address where you are attending the Telehealth session at the beginning of every session. You agree to inform me of the nearest hospital to your primary location that you prefer to go to in the event of a mental health emergency.

There are additional procedures that we need to have in place specific to Telehealth services. These are for your safety in case of an emergency and are as follows:

You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or are in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and Telehealth services are not appropriate.

I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please enter this person's name and contact information below.

Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees to take you to a

hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE

Telehealth by SimplePractice is the technology service we will use to conduct Telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice is NOT an emergency service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth service, neither SimplePractice nor the Telehealth service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by SimplePractice service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice service.
5. To maintain confidentiality, I will not share my Telehealth appointment link with anyone unauthorized to attend the appointment.

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 the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____
Signature of Patient or Personal Representative

_____
Printed Name of Patient or Personal Representative

Date: _____

Description of Personal Representative's
Authority:_____