

**Telehealth Consent**

1. I understand that {enter your name here} wishes to provide services via telehealth technology.
2. My therapist has explained how telehealth sessions are conducted and that we will not be in the same room together.
3. My therapist has explained the benefits of using telehealth as a treatment modality, the convenience of being able to see her from any location I feel comfortable in.
4. I understand there may be some unique issues when using telehealth for my treatment. For example, technological challenges regarding wifi connections and computer/mobile device issues.
5. I understand my therapist will try to assist me with these challenges and resolve any connectivity issues that may arise.
6. My therapist has given me the opportunity to ask questions about this technology and I realize it is my responsibility to ensure I am in a private location and that my therapist will assume she can speak freely about any of my therapeutic goals when we are meeting together.

Consent to Use Telehealth Platforms: I am aware that my therapist uses doxy.me for her Telehealth sessions. I understand this platform is a secure, HIPAA compatible platform and any information we are transmitting is secure and protected. I further understand that I may choose to use a different telehealth platform if I wish. Examples of this would be ZOOM, FaceTime, FaceBook Messenger Video Chat. I understand by opting out of doxy.me, my information may no longer be secure. Lastly, I understand that my telehealth link is confidential, and I will not share it with others.

\*\*\* Insurance: I understand that {enter your name here}, offers and extra service by checking my insurance telehealth benefits before my treatment begins. Anything the insurance company quotes her could be inaccurate and may be subject to change at any time. Furthermore, I understand that I am encouraged to call and check my own benefits as well. I understand that if my insurance fails to cover my services, I am responsible for the full amount of each session. Furthermore, if I have not paid my balance within 60 days of my last service, {enter your name here} has the right to bill my credit card on file for the full amount owed.

By signing this form, I certify: I have read or had this from read and explained to me.

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| --- | --- | --- | --- |
| Signature: |  | Date: |  |