Telehealth is any meeting with a healthcare provider via a phone call or a video call in place of an in-person session.

* I understand that my health care provider wishes me to engage in telehealth as an alternative to an in-person session or sessions, especially given the tenuous nature of medical health risk at the present juncture.
* My provider has explained to me how the video conferencing technology will function and how it will differ from an in-person session.
* I understand that a telehealth session has potential benefits, including greater access to care and the convenience of meeting from a location of my choosing.
* I understand that my insurance provider may not cover any/all of the cost of a telehealth session and I understand that I will owe that balance if the therapist submits to insurance and they fail to pay.
* I understand there are potential risks to this technology, including interruptions, unauthorized access by others, and technical difficulties. I understand that my provider will exercise care to minimize these risks.
* I understand that there will be temptation to do other things while in session virtually but am in agreement that I will remain focused for the session and limit external activities.
* I understand that my provider has taken necessary precautions to assure the software being used (doxy.me) is HIPAA compliant and that while the software my provider will be using may be encrypted or otherwise protected there is a risk of data breach. I agree to not hold my provider liable in cases of data breach other than gross negligence on the part of my provider.
* I understand that my provider or I can or may discontinue the telehealth session if the connection quality or setting is not adequate. The provider will then attempt to contact the client via other means (e.g. phone call). If we choose to use a phone call, I understand that my provider cannot guarantee that any cell phone communications remain completely private.
* I understand that telehealth is not a substitute for in-person psychotherapy and understand my provider may require me to seek out psychotherapy or other mental health services in conjunction with or instead of telehealth.
* I understand that telehealth sessions are not adequate for emergency situations and my provider may require me to contact a local crisis response team or go to the nearest emergency room.
* I have had a direct conversation with my provider, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered, and the risks, benefits, and any practical alternatives have been discussed.

**Consent for using Doxy.me**

Doxy.me is the technology service my provider has selected for use when conducting telehealth video conferencing appointments. It is simple to use, and there are no passwords required to log in. By signing this document, I acknowledge:

* Doxy.me is NOT an Emergency Service, and in the event of an emergency, I will use a phone to call 911.
* Though my provider and I may be having direct, virtual contact through the Telehealth Service, neither Doxy.me nor any telephone conversations will provide any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
* Though Doxy.me facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice, or care.
* I do not assume that my provider has access to any or all of the technical information required to problem solve any session issues with the Doxy.me interface and I understand that sometimes things do not function properly.
* To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.
* I understand that there is a greater risk of a breach of confidentiality if I am not in a safe space and I understand that my therapist has the right to terminate our session if they feel that I am not alone.
* I agree not to record or attempt to record any part of the telehealth session unless I have expressly requested and been given permission to do so by my therapist.

***By signing this form, I certify:***

I have read or had this form read to me or had this form explained to me. I fully understand its contents, including the risks and benefits of Telehealth conferencing. That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Client/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_