TELEHEALTH CONSENT FORM

Patient Name: _____ Medical Record No: _____

1. I understand that due to the COVID-19 coronavirus, precautions are being made through Telehealth sessions for outpatient psychotherapy.
2. At this time, I am choosing to participate in Telehealth sessions with my current practitioner, Dr. Mary Freitag, Integrative Psychological Services, P.A. at https://doxy.me/drmaryfreitag.
3. I understand there are potential risks to this technology, including interruptions due to technical difficulties. Therefore, I or my practitioner may discontinue the Telehealth visit if videoconferencing connections are inadequate.
4. I understand that I may terminate the session at any time and for any reason.
5. I understand that alternatives to a Telehealth session would be to meet with another therapist willing to meet in person, or wait until the COVID-19 quarantine is lifted so to reengage in-person therapy with my current practitioner.
6. I understand that in the event of a crisis, a safety plan will be put in place, which includes any current plan, at least one emergency contact and the closest hospital Emergency Room to my location.
7. I understand that in the event of technical problems, a back-up plan (e.g., phone number where I may be reached) to restart the session or to reschedule will be put in place.
8. I understand that confidentiality still applies for Telehealth services, and no one has the right to record the session without the permission from the other person(s).
9. I agree to engage in Telehealth services in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
10. I understand that my healthcare information may be shared with other individuals for billing and insurance purposes only, just as it may be shared when attending face-to-face sessions. I understand that billing will occur from my practitioner as it occurs with face-to-face sessions.
11. I have 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.
12. I understand that it is important to be on time. If I need to cancel or change my tele-appointment, I will notify my practitioner by phone or email at least 24-hours in advance.
13. I understand that if I fail to notify my practitioner in advance by phone or email at least 24-hours of my need to cancel, I will be responsible for full payment of the session.
14. I understand that if I am not an adult, I must obtain the permission of my parent/legal guardian (and their contact information) for me to participate in Telehealth sessions.
15. It is my (or my parent/legal guardian's) responsibility to confirm with my insurance company that the video sessions will be reimbursed.
16. If the Telehealth sessions are not reimbursed, I am responsible for full payment.

By signing this form, I certify:

- That I have read this form, or had this form read and/or 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 which have been answered to my satisfaction.

_____	_____	_____
Patient's/parent/guardian signature	Date	Time
_____	_____	_____
Witness/Integrative Psychological Services	Date	Time