300 Oxford Drive, Monroeville, PA 15146
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CONSENT FOR TELEHEALTH SESSIONS

1. I understand that my provider has offered tele-health services as an alternative to face-to-face sessions.
2. My provider explained to me how the video conferencing technology that will be used to affect such a session 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 tele-health session 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, at times the video image and audio may be unclear and inadequate, and technical difficulties. I understand that teletherapy is an evolving modality of therapy. As such, there may be potential risks that may not yet be recognized. I understand that my 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. Telehealth services are generally billable through insurance, however I understand that it is ultimately my responsibility to determine if the service will be covered through insurance or if I will be responsible for the cost associated with the service.
7. **Telehealth by Simple Practice** and **Doxy.me** are platforms utilized by Persoma Counseling Associates to administer the tele-health service. Simple Practice and Doxy.me facilitate videoconferencing and are not responsible for the delivery of any healthcare, medical advice or care.
8. To maintain confidentiality, I will not share my tele-health appointment link with anyone unauthorized to attend the appointment.
9. Telehealth is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911. If I need to contact my provider outside of a tele-health session, I will do so through the phone contact information provided to me by my provider.
10. I authorize information about my medical and mental care to be transferred electronically through an interactive video connection between Persoma Counseling Associates and myself/my child.
11. I authorize the release of information pertaining to me/my child to be determined by my mental health care providers or by my insurance company for the purpose of processing insurance claims.
12. I understand that at any time, I may decide to discontinue teletherapy sessions with my provider. My provider will refer me to a local mental health provider who can provide face-to-face services.
13. I understand that information from my teletherapy sessions will be protected by HIPPA privacy laws.

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 treatment.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Name:____ Date:_____________________