PERSOMA
COUNSELING ASSOCIATES

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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. I understand that at each telehealth appointment, for confidentiality I will be asked to identify all persons who will be present in the room with me, giver verbal consent for their participation in my appointment, and identify the role of each person participating in the session.
10. 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.
11. 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.
12. 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.
13. 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.
14. 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:_____