

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my therapist wishes me to engage in a telehealth consultation.
2. My therapist explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/therapist visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation 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, and technical difficulties. I understand that my therapist 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 therapist, 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.

CONSENT TO USE THE TELEHEALTH BY DOXY.ME SERVICE

Telehealth by **DOXY.ME** is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by **DOXY.ME** is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through The Telehealth Service **DOXY.ME**, this service does not provide any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth Service by **DOXY.ME** facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth Service by **DOXY.ME** – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth Service by **DOXY.ME**.
5. To maintain confidentiality, I will not share my **DOXY.ME** appointment link with anyone unauthorized to attend the appointment.

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 the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Signature

Date

Email Address: _____