Natalie Nesbitt, MS LPC
30 S. Valley Rd. 304A
Paoli PA 19301
484-320-7898
natalie@mainlinemarriagecounseling.com

CONSENT FOR TELEHEALTH SERVICES ELECTRONIC COMMUNICATION

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered Telehealth.

If you and your therapist chose to use Telehealth for some or all of your treatment, understand that:

(1) You retain the option to withhold or withdraw consent at any time.
(2) All existing confidentiality protections are equally applicable.
(3) Your access to all medical information transmitted during a Telehealth consultation is guaranteed, and copies of this information are available for a reasonable fee.
(4) Dissemination of any of your identifiable images or information from the Telehealth interaction to researchers or other entities shall not occur without your consent.
(5) There are potential risks, consequences, and benefits of Telehealth. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client.Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.
(6) Confidentiality: I understand that all existing laws regarding my access to medial information and copies of my medical records apply to this Telehealth service. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the Telehealth services. The laws that protect the confidentiality of my medical information also apply to Telehealth services. As such, I understand that the information disclosed is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality which include but are not limited to: reporting child or elderly abuse; expressed threats of violence towards self or a victim. Telehealth is HIPPA compliant to protect my privacy and confidentiality. However, in incidences when there is a “State of Emergency” this provider may use forms of technology that may not meet HIPPA compliancy such as Skype, Google Hangouts, and/FaceTime.
(7) Financial Agreement: You understand that you are responsible for all Telehealth services. Fees associated with Telehealth appointments are payable by credit or debit card only. You agree to provide a credit or debit card information and have it on file with IVY pay. Your card will be billed the same day as the scheduled appointment. If the card is declined, you agree to provide alternative card information to the therapist immediately after session.
(8) Scheduling and cancellation policy: You understand that scheduling is based on the providers normal clinic hours. 24-hour cancellation is required for all Telehealth appointments. You understand that you'll be charged in accordance with the cancellation policy for all no-shows and late cancellations.

TELEHEALTH CONSULTATION:

1. I understand that my health care provider wishes me to engage in a Telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to have such a consultation 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 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 health care 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.

CONSENT TO USE THE TELEHEALTH 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, neither Doxy.me nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth 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 by Doxy.me Service – 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 by Doxy.me Service.
5. To maintain confidentiality, I will not share my Telehealth 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.

______________________________	____________
Name of client	Date of birth
______________________________	____________
Signature of client	Date