



CONSENT FOR TELEHEALTH CONSULTATION

My health care provider 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/health care provider visit due to the fact that I will not be in the same room as my provider.

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.

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. In the event of a technical problem, my provider will contact me by telephone to complete the session and arrange for another time or new connection to try again.

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.

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:

Telehealth by Doxy.me is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.

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.

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.

_____	_____	_____
Client Name (printed)	Client Signature	Date
_____	_____	_____
Therapist Name (printed)	Therapist Signature	Date