TELEHEALTH- INFORMED CONSENT

Client Name: _____

Clinician: Rhona Rosenblatt, LCS 20553

I understand I have the following rights under this agreement:

1. _____ I understand that telehealth treatment involves communication of my mental health information in a technology-assisted format and includes services other than a face-to-face visit exchanged interactively from one site to another through electronic communications. Telephone consultation, patient portals, transmission of still images, and remote therapy sessions are all considered to be telehealth services. I consent to allowing my therapist to use interactive audio, video, and/or data communication regarding my treatment.

2. _____ I understand that telehealth is different from in-person therapy, and that my therapist may decline to provide services via telehealth if she does not deem it in my clinical best interest. My therapist has discussed with me the limitation that she cannot provide identical therapy services via telehealth that she can with a face-to-face visit.

3. _____ I understand that there are limitations specific to telehealth, including but not limited to limitations on my therapist's ability to observe me and accordingly make accurate assessments of my condition. I understand that the focus of telehealth sessions will be support, skill building, resource building, psychoeducation, and consultation. I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental health conditions including personal and relational issues, there is no guarantee that my telehealth or in-person treatment will be effective. My therapist has explained to me that while I may benefit from telehealth, results cannot be guaranteed or assured.

4. _____ I agree that I have verified to my provider my identity and current location in connection with telehealth services, and that failure to do so may terminate our telehealth visit. I also understand that I have a responsibility to verify the identity and credentials of the provider providing care via telehealth.

5. _____ I understand that my therapist requires a Release of information in order to speak with other members of my treatment team, and that without that, she may be unable to continue providing services. I also understand and agree that information exchanged during my telehealth visit will be maintained by my therapist and may be exchanged with other providers involved in my care. I understand that my records and information are governed by state and federal laws that apply to telehealth, and that I may have a right to access my own records.

6. _____ I understand that telehealth cannot be relied on for emergencies or time-sensitive matters. I also understand that there are inherent risks or errors or deficiencies in the electronic transmission of my condition such as during a telehealth visit, which limits my therapist's ability to accurately assess

my condition. I understand that electronic communication should never be used for emergency communications or urgent requests, and that emergency communications should be made to 911 emergency services in my community. If at any time I require emergency or in-person treatment that my therapist is unable to provide, I can be referred to a practitioner who can see me face-to-face, or crisis team who may be able to provide services that my telehealth practitioner cannot.

7. _____ I understand that all electronic communications carry some level of risk. I understand that despite reasonable efforts on the part of my therapist, the transmission of my private information could be inadvertently disrupted or distorted by technical failures. I understand that there are risks unique and specific to telehealth, including but not limited to the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures, could be inadvertently stored, or interrupted or accessed by unauthorized persons, despite assurances from technology platforms regarding confidentiality and HIPAA compliance. Knowing this, I willingly and knowingly wish to proceed with telehealth.

8. _____ I have a right to confidentiality of my medical information, and information disclosed by me during the course of my telehealth is generally confidential. There are, by law, exceptions to confidentiality, including mandatory reporting of suspected child, elder, and dependent adult abuse, and any threats of violence I may make toward a reasonably identifiable person. I understand that if I am in such mental or emotional condition as to be a danger to myself or others, my therapist has the right to break confidentiality as a way to minimize threatened or perceived danger. I understand that the dissemination of any personally identifiable images or information from any telehealth interaction to other entities shall not occur without my written consent.

9. _____ I hold my therapist harmless from any claims I have about the telehealth visit, which includes but is not limited to breaches of confidentiality due to technology platforms relied on for telehealth, breaches of confidentiality caused by a third party or by me, or failures to take necessary steps to address emergencies due to limitations on my therapist's ability to assess me through telehealth. I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others. I understand that it is easier for electronic communications to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.

10. _____ I understand that at any time I may decide to decline telehealth services and see a different practitioner of my choosing, or that I may opt out of the telehealth visit at any time. This will not change the possibility that I may be able to receive future care from this practitioner.

11. _____ I understand that my therapist is only legally allowed to conduct online therapy to clients who live in states where she is a licensed provider of mental health services, unless conducted on an emergency basis or under circumstances that otherwise allow for this. I can ask my therapist about this if I am not certain if she is licensed to practice where I am located, and agree to keep her informed of my location for our sessions.

12. _____ On the day of my appointment, I agree to pay my therapist's regular rate of $175/50 minutes, $230/75 minutes, $275/90 minutes. I understand that this will be collected in the same manner as for a regular office visit. Please note that additional time will be billed in 10 minute increments, such as phone calls between appointments. My therapist does not work with insurance providers and accepts payment in the form of check, Venmo, or Paypal.

I have read and understand the information provided above, and have provided verbal consent as well as written consent, with my signature below, for Rhona Rosenblatt to provide telehealth services to me. I have the right to discuss any of this information with her, and to have any questions I may have regarding my treatment answered to my satisfaction, and I also understand that I may voluntarily withdraw my consent to telehealth communications at any time by providing written notification to my therapist.

My signature below indicates that I have read, understood, and agree to the terms of this agreement and that all blanks were filled in before signing below.

Signed,

Client name _____

Client signature _____ Date _____

Therapist signature _____ Date _____