Telehealth Information and Consent Form

Please read this document thoroughly and completely. To better serve the needs of the community, health care services are now available by interactive video communications and/or by the electronic transmission of information. This process is referred to as "TeleHealth." TeleHealth involves the use of electronic communications to enable healthcare professionals ("Treatment Providers") at different locations to share individual client information for the purpose of improving client care. Treatment Providers may include, but are not limited to, psychiatrists, psychologists, nurses, counselors, clinical social workers, and marriage and family therapists. The information may be used for healthcare delivery, diagnosis, treatment, transfer of medical data, therapy, consultation, follow-up and/or education.

The electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption, including firewalls and password protection.

Since this may be different than the type of consultation with which you are familiar, it is important that you understand and agree to the following statements:

Expected Benefits:

- Improved access and comfort to behavioral health care by enabling a client to remain at a remote site with the Treatment Provider of choice
- More efficient evaluation and management of information
- Obtaining the expertise of a distant specialist

Potential Risks: There are potential risks associated with the use of TeleHealth. These risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate decision making by the Treatment Provider
- Delays in evaluation and treatment could occur due to technical deficiencies or failures
- The transmission of client's personal health information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons; and unauthorized persons. If there is any kind of breach, the Treatment Provider will notify, the client, immediately.

Necessity of In-Person Evaluation: If it becomes clear that the TeleHealth modality is unable to provide all pertinent clinical information during a specific TeleHealth encounter, the Treatment Provider must make it known to the client prior to the conclusion of the live telemedicine encounter. The Treatment Provider must also counsel the client prior to the conclusion of the live TeleHealth encounter regarding the need for the patient to obtain an additional in-person evaluation reasonably able to meet the client's needs.

By signing this form, I understand the following:

- I understand that I have the right to withhold or withdraw my consent to the use of TeleHealth in the course of my care at any time, without affecting my right to future care or treatment.
- I understand that the laws that protect privacy and the confidentiality of personal health information also apply to TeleHealth. I understand that the information disclosed by me during the course of my treatment is confidential. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to information suggesting risk of imminent harm to myself, the client, or others; disclosure of abuse of a current minor child or vulnerable adult; immediate mental or emotional injury to myself; and where I may make my mental or emotional state an issue in a legal proceeding. I also understand that the sharing or release of any personally identifiable images or information from the TeleHealth interaction to researchers or other entities shall not occur without my consent.
- I understand that TeleHealth based services and care may not be as complete as face to-face services. I also understand that if my Treatment Provider believes I would be better served by another form of service (e.g. face-to-face services), I will be referred to a Treatment Provider who can provide such services in my area.
- I understand that a variety of alternative methods of behavioral health care may be available to me, and that I may choose one or more of these at any time. I understand that I may ask my Treatment Provider about alternative methods of care to TeleHealth
- I understand that there are potential risks and benefits associated with any form of treatment, and that despite my efforts and the efforts of my Treatment Provider, my condition may not improve, and in some cases may even get worse.
- I understand that I may expect the anticipated benefits from the use of TeleHealth in my care, but that no results can be guaranteed or assured.
- I understand that in the event of an adverse reaction to the treatment, or in the event of an inability to communicate as a result of a technological or equipment failure, I shall seek follow-up care or assistance at the recommendation of my Treatment Provider.

Information regarding TeleHealth Counseling Services

- Area of Practice: I will practice in my area of licensed jurisdiction, FL.
- Security: It is highly advised that you utilize strong passwords, those that are not easily guessed and contain capital letters, symbols, numbers, and are long. Check if you are using private or public internet access, as information shared on public access may be obtainable by others. Protecting your computer with a firewall is advisable.
- Email & Text: These should be used primarily for confirmation of appointments. I encourage you to write down any relevant information that arises in between sessions to share at our next meeting as opposed to sending via text or email,
- Emergency: call 911, or go to your nearest emergency room. If we need to schedule an immediate session, I will work with you to that. Please do not wait to hear back from me in a time of crisis before contacting 911.

- Session Issues: I will plan to use a web cam. Your responsibility will be to minimize interruptions from your home environment. This is to be treated as your personal time, just as it is in a face to face session. Sessions will be 45 minutes in length.
- Missed Appointments: These are regularly scheduled appointments, please notify me 24 hours in advance if you need to reschedule. Appointments that are missed or cancelled less than 24 hours in advance will be subject to a charge equivalent to the full session fee.

I have read and understand the information provided above regarding TeleHealth and understand I have the opportunity to discuss it with my Treatment Provider. I hereby give my informed consent for the use of TeleHealth in my medical care. Furthermore, I agree that the Released Parties have no liability or responsibility for the accuracy or completeness of the personal health information submitted to them or for any errors in its electronic transmission.

I hereby authorize Sanctuary Counseling LLC / Vivien Morrison LMHC, to use telemedicine or electronic communication in the course of my diagnosis and treatment.

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.

Vivien Morrison, LMHC

Licensed Mental Health Counselor

Signature_____ Date_____