TELEMEDICINE/TELEHEALTH INFORMED CONSENT

I understand that using telehealth allows access to mental health services that might not otherwise be available to me due to the pandemic, my physical or mental health, resources or geographic limitations.
I_____(name or client) hereby consent to engaging in telehealth with Patricia Rowe. I understand telehealth uses interactive audio, video and data communications.

Technology: I understand that I will need to download the application Zoom. The Zoom connection is secure and HIPPA compliant which ensures your privacy. I also need to have a broadband Internet connection or a smart phone device with a good cellular connection at home. If we encounter technical difficulties resolution in service interruptions we can end and restart the session. If we are unable to reconnect within ten minutes, please call me at 510-299-2132 to discuss since we may have to reschedule.

Financial Obligations: Fees associated with telehealth appointments are payable by credit or debit card only. I agree to have my credit/debit card information on file with a secure billing platform. My card will be billed the same day as my scheduled telehealth appointment.

Scheduling: I understand that scheduling is based on Patricia Rowe's normal business hours. Telehealth appointment are not a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the local county crisis line or by dialing 911. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that temelehealth services are not appropriate and a higher level of care is required.

Confidentiality: The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is confidential. However, there are both mandatory and permissive exceptions to confidentiality including reporting child, elder and dependent adult abuse, expressed threat of violence toward an ascertainable victim and where I make my mental or emotional state an issue in a legal proceeding.

Emergency Protocols: I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is:

_____

and my emergency contact person's name, address, phone:

_____

I understand that I have the following rights with respect to telehealth:

1. I have the right to withdraw my consent at any time.
2. I understand that there are risks and consequences associated with telehealth, despite the efforts on the part of Patricia Rowe, that the technical faultier and distortions can arise.

I have read and understand the information provided above.I have discussed it with Patricia Rowe and all of my questions have been answered to my satisfaction. My signature below indicates my informed consent to treatment using this platform.

_____

Client Signature

_____

Date

_____

Provider's Signature

_____

Date