Yellowstone Counseling Center

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TELEHEALTH PATIENT CONSENT FORM

Patient Name: ____ DOB: _________________

Please review and initial to indicate agreement to the following terms:

______ I agree to participate in telehealth therapy to include clinical evaluation, assessment, and on-going mental health treatment. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by
(counselor name) ____.

_______ I understand that my therapist will honor the agreement of confidentiality regarding my mental health evaluation and treatment and will use the HIPAA compliant platform Doxy.me to conduct telehealth sessions and that all reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth session. I understand for my privacy and protection that I will be in a private setting with a secure internet connection. This will help insure that I will have the same confidential environment as if I am in a session at the office.

_______ I understand that I am responsible for obtaining a device equipped with video chat capabilities and securing adequate internet connection. Telehealth sessions may be rescheduled should the video quality become compromised at any time during the session, to the therapist's discretion. Poor video quality under 30 minutes will not be billed and my counselor will make a reasonable effort to reach me to reschedule my session.

_______ I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons.

_______ I understand that if I do not choose to participate in a telehealth session, no action will be taken against me that will cause a delay in my care and that I may still pursue an in-person consultation.

_______ I understand that, as with any technology, telehealth does have its limitations.There is no guarantee, therefore, that telehealth session held will eliminate the need for me to see a mental health therapist, or other medical specialist, in person.

____
Patient Signature　　Date

____
Guardian Signature　　Date