Telehealth Consent Form

Dr. B Virtual Therapy

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Telehealth is a form of telemedicine that allows clients to access psychological care using audio-video interface such as videoconferencing.

Videoconferencing technologies will incorporate network and software security protocols to protect the confidentiality of audio and video data and protect against intentional or unintentional corruption.

Expected Benefits:

* + Improved access to care by enabling a client to remain in his/her home, or while traveling
  + More efficient evaluation and management.
  + Obtaining expertise of a distant specialist.

Possible Risks:

As with any form of healthcare, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

* + In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate decision making by the therapist
  + Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment;
  + In rare instances, security protocols could fail, causing a breach of privacy of personal medical information

By signing this form:

I understand the risks inherent with communicating with Dr. B Virtual Therapy through the internet and through videoconferencing. These risks include the possibility (despite our best efforts to prevent this) that the transmission of medical information could be disrupted or distorted by technical failures in transmission. I also understand that the electronic transmission of medical information could be interrupted or even accessed illegally by unauthorized persons. In addition, I understand that telehealth care may not be as complete as a face-to-face care.. I understand that Dr. B Virtual Therapy has taken steps to provide a level of security that meets or exceeds the current recommendations set forth by Health Insurance Portability and Accountability Act (HIPAA) statutes to help protect my Personal Health Information (PHI) including using third party providers that provide encryption and other methods of security in order to provide reasonable security practices to protect my PHI. However, I also understand that Dr. B Virtual Therapy cannot guarantee that the electronic devices that I will use and the software and applications that run on them (e.g., personal computer, home wifi network, phone, personal Gmail account, etc.) will comply with recommended security standards and that I accept responsibility for any risks these devices may pose to the protection and integrity of my personal health information.

Initial ……….

I understand that I may increase the security and integrity of my video teleconferencing therapy sessions by utilizing good security practices including but not limited to the following: keeping the operating system updated with all updates and patches; appropriately utilizing antivirus and malware software; utilizing robust and confidential passwords and other security measures; using a private, secure WiFi network; and conducting sessions in a private location.

Initial ……….

I understand that I must have a backup voice system in case there is a problem with the video teleconferencing system. I can be contacted at the following phone number in case there is a problem with the session:

Initial ……….

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to other entities without my consent. My video telehealth visit will not be recorded and all identifying information in the interaction will be kept secure in the same manner as any other private medical information.

Initial ……….

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.

Initial ……….

I understand that I have the right to inspect all information obtained in the course of a telehealth interaction, and may receive copies of this information for a reasonable fee.

Initial ……….

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.

Initial ……….

I have read and understand the information provided above regarding telehealth, have discussed it with my therapist, psychiatrist or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychology in my care with Dr. B Virtual Therapy.

I hereby authorize Dr. B Virtual Therapy to use telehealth in the course of my diagnosis and treatment.

…………………………… ………………………………

Name Date of Birth

……………………………… …………………………………

Signature Date