SPENCER PSYCHOLOGY

Consent for Telehealth Services

I _____ consent to telehealth services (e.g., internet or telephone based therapy) with Spencer Psychology as a venue for my psychotherapy treatment. I understand that telehealth includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of psychotherapy data, and education using interactive audio, video, and/or data communications. I understand that I have the following rights with respect to telehealth:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment

(2) The laws that protect the confidentiality of my psychological/medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence or harm to myself or others; and where I make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

(3) I understand that there are risks and consequences from telehealth. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical/psychological information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; the electronic storage of my medical/psychological information could be accessed by unauthorized persons and/or misunderstandings can more easily occur. In addition, I understand that telehealth based services and care may not yield the same results nor be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I will be referred to a psychotherapist in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some cases may even get worse.

(4) I understand that I may benefit from telehealth, but results cannot be guaranteed or assured. The benefits of telehealth may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

(5) I understand that I have the right to access my medical/psychological information and copies of my records in accordance with Indiana law, that these services may not be covered by insurance and that if there is intentional misrepresentation, therapy will be terminated.

I have read and understand the information provided above, which has also been explained to me verbally. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

I agree that I will only participate in telehealth while I am physically located in Indiana , the state in which my Spencer Psychology therapist is licensed. I agree I will not misrepresent my physical whereabouts.

Signature_____ Date _____