Process Therapy Institute

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Consent for Telehealth Consultation

Client Name:_____
Print First and Last Name

hereby consent to engaging in telehealth with:

_____,
Name of Psychotherapist

an employee of Process Therapy Institute, Incorporated, as part of my psychotherapy. I understand that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California or outside of California.

1. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
2. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing. Results cannot be guaranteed or assured.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
5. I understand that I have the following rights with respect to telemedicine: I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment and risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
6. The laws that protect the confidentiality of my 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 towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.
7. I understand that telehealth used services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services I will be referred to a psychotherapist who can provide such services in my area. 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.
8. I understand that I have a right to access my medical information and copies of medical records with accordance with California law. I have read and understand the information provided above. I have discussed this with my psychotherapist, and all of my questions have been answered to my satisfaction.
9. Telehealth is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
10. I understand the telehealth psychotherapist will be available, holding open the appointment for 15 minutes. Being later than 15 minutes for my phone call will require me to reschedule.
11. My psychotherapist requires a 24 hour notice to cancel and reschedule visits. If not canceled, I will be charged my regular session fee for the missed session.

By signing this document, I am agreeing that I have read, understood and agreed to the items contained in this document. If verbal consent if given, psychotherapist should note such on Client signature line and date.

_____
Signature of client/parent/guardian/conservator

_____
(if signed by other than patient indicate relationship)

_____
Date

_____
Signature of psychotherapist