Gold Counseling Services

Informed Consent for Telehealth Services

Client Name: _____ **Date of Birth:** _____

I understand that telehealth is the use of video and audio technologies to provide services between a health care provider and their clients when they are in different locations. I understand that Gold Counseling Services, P.C. utilizes a HIPAA compliant video platform. My therapist has provided information as to how this technology may be accessed for telehealth services when my therapist and I cannot be in the same physical location.

I understand the following about the use of Telehealth services:

1. There are potential risks to use of technology and electronic communications, including interruptions, unauthorized access and technical difficulties. I agree that the therapist and practice will not be held responsible if any outside party gain access to my/my child's personal information by bypassing the security measures of the communication system.
2. I understand that my health care provider(s) or myself can discontinue the telehealth session if it is determined that the connection is inadequate for a video session. I can choose to continue the session via phone or reschedule the remaining time, but understand I am responsible for payment of the full session.
3. The laws that protect privacy and the confidentiality of client information also apply to telehealth. Sessions are encrypted and confidential. I agree not to make or allow audio or video recordings of sessions and understand my therapist will not record any portion of the sessions. I will make efforts to be in a private physical location during sessions in order to protect my/my child's privacy.
4. I understand that not all insurance carriers cover telehealth services; if I plan to use my insurance for telehealth, it is my responsibility to inquire about the benefits under my insurance plan.
5. I understand that this form is signed in addition to the Client Service Agreement and Notice of Privacy Practices and that all practice policies and procedures apply to telehealth services. If my therapist determines that telehealth is not appropriate for me/my child, I understand that I will be provided with appropriate referrals to transition services to another provider if necessary.
6. I understand that if there is an emergency during a telehealth session, then my therapist may call emergency services and/or my emergency contact.
7. I understand that I have the right to withhold or revoke my consent to the use of telehealth services in writing at any time by contacting my therapist at Gold Counseling Services, P.C. As long as this consent has not been revoked, I understand that health care services may be provided to me via telehealth throughout the course of receiving services.

I hereby give my informed consent for the use of telehealth care services in my/my child's care.

_____ _____
Client Signature (age 12 and older) Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date