Telemedicine/Telehealth Informed Consent

I _____ hereby consent to engage in telemedicine/telehealth (e.g., internet, email or telephone based therapy) with _____(clinician) as the main mode of my psychotherapy treatment. I understand that telemedicine includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that telemedicine may involves the communication of my medical/mental health information, both orally and visually, to other health care practitioners.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. 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. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

I also understand that the dissemination to researchers or other entities, of any personally identifiable images or information from the telemedicine interaction shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my clinician, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.

In addition, I understand that telemedicine-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 clinician believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I will be referred to a clinician 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 clinician, my condition may not improve and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine, but results cannot be guaranteed or assured. The benefits of telemedicine 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 information and copies of medical records in accordance with California law, that these services may not be covered by insurance, and that, if there is intentional misrepresentation, therapy will be terminated.

Alo.ha Psych Associates, Inc. recommends Zoom technology, a HIPPA compliant video and phone conferencing service, to provide teletherapy services. A secure link for telemedicine services will be provided, and we will assist you in understanding how to use this program. Sessions will be billed according to the original fee agreement. Late cancellation fees may still apply, depending on the individual case and circumstances. Telemedicine services can be declined at any time, just like an in-person session can. Confidentiality still applies for telepsychology services. Please see the originally signed informed consent document for a review of all limits to confidentiality. All information provided in the original informed consent document still apply. Nobody will record the session without the permission from the others person(s).

Clinician Responsibilities. We will conduct your session from a private and confidential space. If at any time the telehealth space is deemed no longer private, we will work with you to end the session appropriately. If technological problems disrupt the therapy, you will be contacted via phone or email to continue the session or to reschedule the session using an agreed upon plan. We will continue to schedule regular appointments and keep records of your sessions. We will continue to assess the appropriateness of receiving telehealth services as agreed upon in this informed consent document. If needed, we will offer to modify the plan or provide referrals as needed if it is deemed that telehealth services are no longer appropriate for your care or safety. In addition, we may determine that due to certain circumstances, teletherapy is no longer appropriate for your care, and that we should resume our sessions in-person.

Patient Responsibilities. I agree to engage in teletherapy. I also agree to use the telephonic or video-conferencing platform selected and agreed upon for our teletherapy sessions. I agree to make efforts to have the necessary access to the technology needed to participate in the services provided. This may include, but is not limited to, a telephone, computer, internet connection, and/or Zoom software (Zoom requires a free download). I agree to connect with my clinician from a quiet, private, and confidential space that is free of distractions (including cell phone or other devices) during the session. I understand that I cannot receive therapy when I am in a public location where people can overhear or see my therapy session. I understand that it is important to use a secure internet connection rather than public/free Wi-Fi. I agree to inform my

clinician if the need for in-person services arises, or if I need additional resources or referrals. In an emergency, I will contact 911 or use another service available to me. This includes, but is not limited to, services recommended by my clinician. If you are unsafe, we need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation. If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telemedicine sessions.

I have read and understand the information provided above regarding telehealth services. I have discussed it with my clinician and all of my questions have been answered to my satisfaction. This document does not replace other agreements or consents established as part of my treatment or the informed consent process. I understand the risks inherent to interactive technology. My signature indicates acknowledgement of these risks and releases the clinician, and alo.ha psych associates, inc. from any liability associated with interactive technologies

Signature and Consent for telemedicine/telehealth:

Name _____ Date _____

Signature: _____