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Telehealth Consent Form

Patient Name: _____

DOB: _____

1. For medical, (Covid-19) or transportation reasons, I choose to work with Joanna C. Ioannides, LCSW, who is authorized to provide telehealth mental health services.

2. My mental health care provider has explained to me how the video conferencing technology will be used, and that such a consultation will not be the same as a direct patient/ mental health care provider visit due to the fact that I will not be in the same room as my mental health care provider.

3. I understand there are potential risks to this technology, including interruptions. I understand that I must use the telehealth technology ascribed by mental health therapist, as it is HIPPA-compliant. Due to Covid-19, I understand that should the internet be overwhelmed, the Department of Health and Human Services has loosened restrictions on telehealth, and Facetime, Skype or other non-Hippa protected sites can be used in case of hippa-protected site "Doxy.me" not functioning during session. I understand that my mental health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my mental health care information may be shared with other individuals for scheduling and billing purposes. The above mentioned person will maintain confidentiality of the information obtained. I further understand that I can terminate the consultation at any time, and that this third party is only privy to my name, dob, insurance id number, date of service, and code of treatment and diagnoses.

5. I have had the alternatives to a telemedicine consultation explained to me, and am choosing to participate in a telehealth session. I understand that I can get a second opinion at any time, or may terminate therapy and seek another therapist at any time.

6. In an emergent consultation, I understand that the responsibility of the telehealth therapist is to advise my local practitioner and that the telehealth therapist's responsibility will conclude upon the termination of the video conference connection.

7. I understand that billing will occur from my practitioner.

8. I have had a direct conversation with my telehealth therapist, 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.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____
Patient's/parent/guardian signature Date

_____ _____
Clinician Signature Date