Barbara Lauer, LCSW

Telehealth Informed Consent

DEFINITION OF TELEHEALTH

Telehealth involves the use of electronic communications to enable clinicians to connect with individuals using live interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

YOUR RIGHTS

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

1. The laws that protect the confidentiality of my personal information also apply to telehealth. A copy of the HIPAA Confidentiality Agreement that was signed at intake can be provided.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the therapist, that the transmission of my personal information could be disrupted or distorted by technical failures, interrupted by unauthorized persons, and/or that the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. I utilize a secure, encrypted, HIPAA-compliant audio/video transmission software to deliver telehealth via Doxy.me.
4. I follow State of Oregon and NASW board regulations and ethical standards for telehealth.
5. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-, video-, or computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility.

PAYMENT FOR TELEHEALTH SERVICES

I will bill insurance for telehealth sessions when they are covered by an individual's insurance plan. The standard copay and/or deductibles will apply. In the event that insurance does not cover telehealth, or when there is no insurance coverage, clients may pay out-of-pocket. I can provide a statement to submit to your insurance company.

PATIENT CONSENT TO THE USE OF TELEHEALTH

I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction. I have read this document carefully, understand the risks and benefits related to the use of telehealth services, and have had my questions regarding the procedure explained.

I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I state that I have read, understood, and agree to the terms of this document.

SIGNATURES

Please complete and return this form to your provider.

Signature

Date

Printed Name