Professional Psychological Services

WWW.PROFESSIONALPSYCH.COM
INFO@PROFESSIONALPSYCH.COM

3331 Duke Street • Alexandria • VA • 22314 • TEL 703.879.2482 • FAX 703.879.2483

Informed Consent for Telehealth Services

I _____ [name of patient] hereby consent to engaging in telemedicine at Professional Psychological Services (PPS) as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications.

Technology: I understand that I will need to download an application and/or software to use this platform. I also need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services.

Financial Obligations: PPS will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. In the event that insurance does not cover telehealth, the individual wishes to pay out-of-pocket, or when there is no insurance coverage, a prompt pay discount is available. Please contact PPS to discuss further.

Confidentiality: 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 which is outlined in the Client Service Agreement. The Telemedicine platform that PPS will use is HIPAA compliant to protect privacy and confidentiality.

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

1. I have the right to withdraw my consent at any time.

2. I understand that there are risks and consequences associated with telehealth including, but not limited to the possibility, despite reasonable efforts on the part of my counselor that the transmission of my medical information could be disrupted or distorted by technical failures. In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services.

3. I understand that I may benefit from telehealth but that results cannot be guaranteed or assured.

4. I understand that I have a right to access my mental health information and copies of medical records in accordance with Virginia law.

I have read and understand the information provided above. My signature below indicates my informed and willful consent to treatment using this platform.

_____ _____
Printed name of client Date

_____ _____
Signature of client Date

_____ _____
Signature of parent/legal guardian (if under 18) Date