Vanessa Townsend, Psy.D
Licensed Psychologist

Steven P. Dingfelder, Ph.D.
Licensed Psychologist

Michael Meehan, LCSW
Licensed Clinical Social Worker

Melanie Nuszkowski, Ph.D.
Licensed Psychologist

Stuart Townsend, Psy.D.
Licensed Psychologist

Ralph Wyman, LMHC
Licensed Mental Health Counselor

Jane Echterling, Ph.D.
Licensed Psychologist

Kelly Weidner, LMHC
Licensed Clinical Social Worker

Dr Townsend & Associates

Comprehensive Counseling Services

Informed Consent for Telehealth Services

PATIENT NAME: _____

LOCATION OF PATIENT: _____

DATE OF BIRTH: _____

TELEPHONE #: _____

THERAPIST NAME: _____

DATE OF CONSENT: _____

Telehealth in our practice involves the use of technology, either telephone or video to conduct diagnosis and therapy for those individuals who are unable access our office.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits: · Improved access to mental health care by enabling a patient to remain in his/her home (or at a remote site) while the therapist provides outpatient mental health counseling by telephone or telehealth video service for continuity of care during a time of crisis that prevents the patient from attending his/her session in person.

Possible Risks: As with any medical service, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:
· In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate decision making by the therapist(s); In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information

Informed Consent for Telehealth:

By signing this form, I understand the following:
1. I understand that the laws that protect privacy and the confidentiality of medical and mental health information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
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 telemedicine may involve electronic communication of my personal medical or mental health information to other medical practitioners.
4. I understand that if the telephone or video session fails in anyway, that my clinician will make every attempt to reach back out to me.

Patient Consent To The Use of Telehealth:

I have read and understand the information provided above regarding telehealth, have discussed it with my clinician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my outpatient mental health care. I hereby authorize _____ (name of clinician) to use telehealth in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient):

_____

Date: _____

If authorized signer, relationship to patient:

Witness:_____

Date:_____

I have been offered a copy of this consent form (patient's initials) _____