Green House Group, PA

Psychotherapy and Consultation

250 Commercial Street, Suite 3004 * Manchester, NH 03101 * (603) 668-3050 * Fax (603) 668-8666

INFORMED CONSENT FOR TELEHEALTH CONSULTATIONS

I, ____ (client), hereby consent to engaging in telehealth services with ______________________________________ (name of psychotherapist) as part of my treatment. Telehealth psychotherapy will generally occur through interactive video communications and sometimes through audio-only telephone. I will confirm coverage of telehealth services through my insurance plan. Telehealth consultations do not include communications by electronic mail, text, or fax and these services are not reimbursed by most insurance plans.

I understand that receiving telehealth psychotherapy is an added service to my existing treatment through the Green House Group, P.A., 250 Commercial Street, Suite 3004, Manchester, NH, 03101. As such, I maintain my consent to treatment and acknowledgement of privacy practices and financial policies, which are located in my clinical file. In addition, I understand that I have the following rights and understandings with respect to telehealth:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future treatment.

(2) As an extension of my confidentiality, I understand that the dissemination of any personally identifiable images, recordings, or other information from the telehealth interaction to other entities shall not occur without written consent and agreement by both myself and the psychotherapist. In addition, both my psychotherapist and I will inform each other when any additional persons are to be present during telehealth services.

(3) I understand that telehealth based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of intervention (e.g. face-to-face services), alternative treatment options will be discussed and appropriate referrals will be defined.

(4) I understand that there are risks and consequences from telehealth despite reasonable efforts of the psychotherapist. Such consequences are relative to internet service providers, computer software/hardware, etc., and include, but are not limited to: disruption or distortion in transmission of my personal information by technical failures; the transmission of my personal information could be interrupted by unauthorized persons; and/or the electronic storage of my personal information could be accessed by unauthorized persons.

(5) I understand that use of audio/video systems are not 100% secure. All attempts to abide by HIPAA federal privacy laws will be made, but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. I will not hold this therapist liable for any gathering or use of client information by these service providers.

(6) By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio/video/ 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 in my immediate area. By signing this document, I acknowledge I have been told that if I feel suicidal, I am to call **9-1-1** or the National Suicide Hotline at **1-800-273-8255** or other local suicide hotlines.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

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Signature of client/parent/guardian / Date — Date of birth

____

Printed name of client/parent/guardian and relationship to client (as clearly as possible) — Preferred email address

____

Emergency contact name and phone number

____

Signature of telehealth psychotherapist — Date