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FOR PROFESSIONAL SERVICES

TELEHEALTH CONSENT

for telephone and virtual (VSee) sessions

Client Name: _____ Date: _____

1. I understand my mental healthcare provider ("*provider*") has offered telehealth sessions due to specific circumstances.
2. My provider has explained to me how to utilize the HIPAA compliant synchronous platform technology, and that this format is not the same as direct client/provider visit since I will not be in the same physical space as my provider.
3. I understand that there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my provider or I may discontinue the telehealth session if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other third parties for scheduling and billing purposes as per usual as is the case for in-person sessions.
5. I understand and agree that in order to preserve confidentiality, I will be in a private room with a closed door without any other individuals present in person or online. Only myself and my provider will be participating in the session unless it has been previously agreed to have a family session or other support person present.
6. I understand that I am financially responsible for telehealth sessions in the same manner as in-person office sessions and I agree to pay the fee agreed upon with my provider.
7. I have had a direct conversation with my provider, during which I had the opportunity to ask questions regarding telehealth sessions. 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.

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By signing this form, I certify:

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

Client's/Parent's/Guardian's signature	Date and Time
Witness' signature	Date and Time

Ketaki Vaidhyanathan, MD