North Star Wellness
Find your way

Po Box 1075 Montpelier VT 05601 - Phone: 802.252.2579 - Fax: 855.494.1575

CONSENT FOR TELEHEALTH

Please read this consent form carefully, as it describes the policies and procedures followed by your counselor for providing remote counseling services. This is in addition to the original informed consent and practice policies you received at or prior to your first appointment.

1. Remote therapy includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. Clinicians follow the laws and professional regulations of the State of Vermont and all states in which they are licensed.

2. I understand that my health care provider wishes me to engage in telehealth treatment. I understand that telephone/online psychotherapy is not a substitute for medication under the care of a psychiatrist or doctor. As with all therapy, results cannot be guaranteed or assured.

3. My health care provider explained to me how the video conferencing technology that will be used will not be the same as a direct client/health care provider visit. I understand that remote sessions have limitations compared to in-person sessions, among those being the lack of “personal” face-to- face interactions, the lack of visual and audio cues in the therapy process, and the fact that some insurance plans will not cover this type of therapy.

4. I understand that telehealth has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

5. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the conditions are not adequate for the situation.

6. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. 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.

CONSENT TO USE THE TELEHEALTH BY SIMPLE PRACTICE SERVICE

Telehealth by SimplePractice is the technology service we will use to conduct telehealth appointments. By signing this document, I acknowledge:

1. Telehealth is NOT an Emergency Service and may not be appropriate when experiencing a crisis, or having suicidal or homicidal thoughts. If a life-threatening crisis should occur, I agree to contact a crisis hotline, call 911, or go to a hospital emergency room.

2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.

3. Clinician availability is not substantially changed by engaging in telehealth. Clinicians will not be available on-demand outside scheduled appointment times.

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4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service, and understand some technical problems are beyond their control.

5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment. I agree to control access to my device and electronic information and communicate at a location where confidentiality can be ensured.

6. Counselors will never acknowledge working therapeutically with anyone without his/her written permission and will not accept any invitations or connect with clients via social networking platforms. Due to geolocation technology, networking and marketing algorithms, all digital communication and devices are a potential risk to privacy in ways that are outside our control.

7. I am responsible for providing the necessary computer, telecommunications equipment and internet access for sessions, and arranging a location with sufficient lighting and privacy that is free from distractions or intrusions.

8. Insurance may not cover online therapy, I will verify my plan coverage before my first appointment. I understand late cancellation and no-show fees apply as with in person appointments.

By signing this form, I certify:

· That I have read or had this form read and/or had this form 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 any questions have been answered to my satisfaction.

MY SIGNATURE BELOW INDICATES THAT I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature Printed Name Date

Guardian Signature Printed Name Date