Informed Consent to Telehealth

I ____(Insert Name and DOB), hereby consent to participating in psychotherapy via phone or the internet (hereinafter referred to as **Telehealth**) with Evi Fisher MA LCAT

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video, or data communication regarding my treatment. I understand I have the following rights under this agreement: I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

By law, there are exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my psychotherapist has the right to break confidentiality to prevent the threatened danger. Furthermore, I understand that sharing personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

I understand that while psychotherapy of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. I understand that fees and billing for Telehealth will be identical to that for similar in-person services, and that if I choose to submit receipts to my insurance that my insurance may not cover these services given that Evi Fisher is an out-of-network provider and/or because they do not support Telehealth services. I understand that while I may benefit from Telehealth, results cannot be guaranteed. I understand that my psychotherapist will use a secure technology compliant with privacy and confidentiality laws and guidelines to connect with me for Telehealth sessions. However, I also understand that there are risks unique and specific to Telehealth, such as the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons despite reasonable security measures. I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapy, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services. I have the right to discuss any of this information with my therapist.

We will meet on Doxy.me, which is a telemedicine platform that is HIPAA compliant. This platform is encrypted to the federal standard, HIPAA compliant, and has signed a HIPAA Business Associate Agreement with me. This BAA means the Doxy.me attests to HIPAA compliance and assumes responsibility for keeping our interaction secure and confidential. You do need to have access to a strong consistent internet connection for this technology. If secure technology is not available and we agree to another form of communication (phone or other

interface), I recognize this is not a secure form of communication and privacy and confidentiality cannot be guaranteed.

I agree that each time we meet online I will provide the address I am are located at, if I am in a place where I can speak confidentially, and if I expect we might be interrupted.

Below is the information of the nearest mental health hospital to my primary location that I prefer to go to in the event of a mental health emergency (usually located where you will typically be during a Telehealth session), should you not be located in Saratoga Springs where you have access to either Saratoga Hospital or Four Winds Saratoga. Please list this hospital and contact number here:

Hospital: ____

Phone: _______________________

The Telehealth sessions shall not be recorded in anyway unless agreed to in writing by mutual consent, prior to the session.

This agreement is intended as a supplement to the general Informed Consent to Treatment agreement that you also sign prior to our psychotherapy treatment.

I understand that Telehealth treatment is different from in-person therapy and that my psychotherapist will only use this medium of psychotherapy for a brief period as clinically necessary until I may be better served by another form of psychotherapy, such as in-person treatment. I have the right to discuss any of this information with my psychotherapist.

____ ____________________

My Signature Date

____ ______________________

Provider Signature Date