Costa Clinical Psychology, LLC

Patient Name: _____ Medical Record No: _____

Consent for Telehealth Services

1. I understand that my Mental Health Care Provider wishes me to engage in telemedicine consultation and therapy sessions.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation and ongoing therapy sessions. I understand this will not be "In Person', and the same as a direct patient/health care provider visit due to the fact I will not be in the same room as my mental health care provider and will be in a remote (off site) location.
3. 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 telemedicine consult/therapy 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 individuals for scheduling and billing purposes only. All security measures will be made to safeguard my mental health information from unauthorized access.
5. I have had the alternatives to telemedicine explained to me and understand that I have the right to discontinue the telemedicine anytime I choose to do so and opt for other methods to achieve my mental health goals.
6. In emergency consultations I understand that my therapist may need to contact outside agencies to assist during a mental health crisis.
7. I understand that billing will occur as a result of the use of telemedicine.
8. I have had a direct conversation with my Mental Health 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 that I understand.

By signing this form, I certify:

1. That I have read or had this form read and/or explained to me.
2. That I fully understand its contents including the risks and benefits of utilizing telemedicine.
3. That I have been given ample opportunity to ask questions and any questions have been answered to my satisfaction.

_____ _____ _____

Patient's/Parent/Guardian Signature Date Time

_____ _____ _____

Witness Signature Date Time