Healing Day Counseling&Psychotherapy Services

797 Washington Street Suite 4 Newtonville, MA 02460 phone: 617-820 8895

CONSENT FOR TELEHEALTH INDIVIDUAL/COUPLES THERAPY

1. I understand that my health care provider wishes me to engage in couples therapy via Telehealth..

2. The provider explained to me how the video conferencing technology that will be used to affect such therapy will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.

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

4. 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 therapy if it is felt that the videoconferencing connections are not adequate for the situation.

5. 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 ZOOM/DOXY/FACETIME PLATFORM FOR TELEHEALTH

By signing this document, I acknowledge:

1. Telehealth via Zoom/Doxy/Facetime is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.

2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, Zoom/Doxy/Facetime does not provide any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.

3. Zoom/Doxy/Facetime facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.

4. I do not assume that my provider has access to any or all of the technical information in the Zoom/Doxy/Facetime Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Zoom/Doxy/Facdtiem Service.

5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

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 of the procedure(s).

- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____	_____	_____
NAME LAST NAME	SIGNATURE	DATE