Healing Day Counseling & Psychotherapy Services

Phone: 617-820-8895 email: ckbetebenner@healingdaytherapy.com

CONSENT FOR TELEHEALTH INDIVIDUAL/COUPLES THERAPY

1. I understand that my healthcare provider wishes me to engage in individual or couples therapy via Telehealth.

2. I understand and acknowledge that video conferencing technology used for therapy is different from in-person visits because I will not be in the same physical space as my provider.

3. I recognize that Telehealth therapy has potential benefits, including increased accessibility and the convenience of participating from my chosen location.

4. I acknowledge potential risks associated with Telehealth therapy, including but not limited to technical interruptions, unauthorized access, and connectivity issues. I understand that my healthcare provider or I may discontinue Telehealth therapy if the quality of the videoconference is inadequate.

5. I confirm that I have discussed this procedure directly with my provider. I have had an opportunity to ask questions, and all my questions about the risks, benefits, and alternatives have been satisfactorily answered.

CONSENT TO USE ZOOM/DOXY/FACETIME FOR TELEHEALTH

By signing this document, I acknowledge:

1. Telehealth via Zoom/Doxy/Facetime is NOT an emergency service. In an emergency, I understand that I should call 911 immediately.

2. Zoom/Doxy/Facetime facilitates videoconferencing only and does not provide medical advice or healthcare services.

3. Zoom/Doxy/Facetime is not responsible for the delivery of healthcare or medical services.

4. My healthcare provider may not have access to technical details of Zoom/Doxy/Facetime, nor is the accuracy or currency of any such technical information guaranteed.

5. To protect confidentiality, I agree not to share my telehealth session links with anyone unauthorized to attend the sessions.

By signing below, I certify:

- I have read or had this consent form explained to me.
- I fully understand the contents, including risks and benefits associated with Telehealth therapy.
- I have had adequate opportunity to ask questions and have received satisfactory answers.

NAME LAST NAME SIGNATURE DATE