MIDDLETOWN COUNSELING SERVICES, INC.

1. I understand that my Social Worker, Counselor, Therapist recommends engaging in telehealth services with me to provide treatment.

2. I understand this is out of necessity and an abundance of caution and has originated due to the Coronavirus (Covid-19) pandemic.

3. I understand that telehealth treatment has potential benefits including, but not limited to, easier access to care.

4. I understand that telehealth has been found to be effective in treating a wide range of disorders, and there are potential benefits including, but not limited to easier access to care. I understand; however, there is no guarantee that all treatment of all patients will be effective.

5. I understand that it is my obligation to notify my therapist of my location at the beginning of each treatment session. If for some reason, I change locations during the session, it is my obligation to notify my therapist of the change in location.

6. I understand that it is my obligation to notify my therapist of any other persons in the location, either on or off camera and who can hear or see the session. I understand that I am responsible to ensure privacy at my location. I will notify my therapist at the outset of each session and am aware that confidential information may be discussed.

7. I understand that it is my obligation to ensure that any virtual assistant artificial intelligence devices, including but not limited to Alex, Echo or Siri, will be disabled or will not be in the location where information can be heard.

8. I agree that I will not record either through audio or video any of the session, unless I notify my therapist and this is agreed upon.

9. I understand there are potential risks to using telehealth technology, including but not limited to, interruptions, unauthorized access, and technical difficulties. I understand some of these technological challenges include issues with software, hardware, and internet connection which may result in interruption.

10. I understand that my therapist is not responsible for any technological problems of which my therapist has no control over. I further understand that my therapist does not guarantee that technology will be available or work as expected.

11. I understand that I am responsible for information security on my device, including but not limited to, computer, tablet, or phone, and in my own location.

12. I understand that my therapist or I (or, if applicable, my guardian or conservator), can discontinue the telehealth consult/visit if it is determined by either me or my therapist that the videoconferencing connections or protections are not adequate for the situation.

By signing this document, I acknowledge:

1. In the event of an emergency, I will use a phone to call 9-1-1 and/or other appropriate emergency contact.

2. I recognize my therapist may need to notify emergency personnel in the event he/she feels there is a safety concern, including but not limited to, a risk to self/others or my therapist is concerned that immediate medical attention is needed.

3. I understand should medical services be required; I will contact my physician. If emergency services are needed, I understand I should call 9-1-1.

4. I understand that the same fee rates apply for telehealth as apply for in-person treatment. ++It is my obligation to contact my insurer before engaging in telehealth to determine if there are applicable co-pays or fees which I am responsible for. Insurance or other managed care providers may not cover telehealth sessions. I understand that if my insurance, HMO, third-party payor, or other managed care provider do not cover the telehealth sessions, I will be solely responsible for the entire fee of the session @ 75.00 per session.

5. To maintain confidentiality, I will not share my telehealth appointment link or information with anyone not authorized to attend the session.

6. I understand that either I or my therapist can discontinue the telehealth services if those services do not appear to benefit me therapeutically or for other reasons which will be explained to me.

I understand there may be no other treatment alternative available. I have read and understand the information provided above regarding telehealth, and I hereby give informed consent to the use of telehealth.

_____

Signature of patient (or guardian/conservator)

_____

Printed name

_____

Date