Please read and initial each statement.

_____ Telehealth allows my medication prescriber and therapist to diagnose and treat me using secure, confidential, and private (HIPAA approved) interactive audio and video platforms. I understand that the same laws that protect my medical information for in-person treatment apply to Telehealth.

_____ I understand that my session will NEVER be recorded and saved for any purpose by me or my provider.

_____ I understand that there are exceptions to confidentiality including (a) mandatory reporting of child, elder, and dependent adult abuse; (b) threats of violence made toward a reasonably identifiable person; (c) imminent threats of self-harm or suicide. I understand that my prescriber and therapist have a legal responsibility to waive my confidentiality to prevent the threatened danger to myself and others.

_____ I understand that there are unique problems and potential risks specific to Telehealth including technical failures that disrupt scheduled sessions and the potential for access by unauthorized sources.

_____ I understand that Telehealth treatment is different from in-person treatment and that my provider may recommend returning to face-to-face appointments.

_____ I understand that my provider is not legally allowed to conduct Telehealth if I am out of state or country. I must be in Virginia for Teletherapy appointments. I understand that my provider will ask me to verify my current location to fulfill this legal requirement.

_____ I understand Virginia Law requires me to show a copy of my state issued photo ID to confirm my identity each session.

_____ I understand that the same attendance and cancellation policies that apply to my face-to-face appointments apply to my Telehealth appointments. If I am more than 10 minutes late, I am subject to a no-show fee. I am responsible for scheduling my next appointment.

_____ I understand that I am responsible for providing the computer with camera and secure internet access in my location.

_____ I understand that I am responsible for arranging a private location that is free from intrusions, distractions, or access by unauthorized persons (e.g., public places, while driving).

_____ I understand that to use Telehealth, I agree to provide two emergency contacts and the location of the closest hospital in case of an emergency. Emergency is defined as a person who is a danger to self; danger to others; unable to protect self from harm or provide for basic human needs due to mental illness. In this case, I will be referred to a higher level of care in accordance with Virginia Laws.

_____ I understand that I will be asked to give my verbal assent (permission) to use the Telehealth platform for my session up until I sign and submit the formal consent form.

_____ I understand that my provider(s) will answer any questions about this consent form and that I can withdraw my consent to Telehealth communications at any time.

Please complete the following information.

Client's physical address during Telehealth appointments:

Name: _____

Address: _____

City / State: _____ Zip code: _____

Cell phone: _____ Secondary phone: _____

Email address: _____

First Emergency Contact:

Name: _____

Relationship to client: _____

Cell phone: _____ Secondary phone: _____

Second Emergency Contact:

Name: _____

Relationship to client: _____

Cell phone: _____ Secondary phone: _____

Nearest Hospital to Client:

☐ Sentara Williamsburg Regional Medical Center Phone: 757-984-6000

☐ Riverside Doctors Hospital Williamsburg Phone: 757-585-2200

☐ Other: _____ Phone: _____

I hereby consent to participate in Telehealth via secure internet connection with the provider(s) listed below:

Prescriber: _____

Therapist: _____

My signature indicates that I have read this Consent Form and I agree to its terms.

Print your name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____