Pathways Counseling Services, PLLC
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Scottsdale, AZ 85260
480.235.1682
Info@PathwaysCounselingSvcs.com

Informed Consent for Telehealth

Client NAME: _____ DATE OF BIRTH: _____

By signing this form for myself or my minor child, I understand the following:

1. I understand that telehealth or teletherapy involves the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to receiving health care services to me or my minor child via telehealth over secure video conferencing platform.

2. I understand that the laws that protect privacy and the confidentiality of my medical information also apply to telehealth or teletherapy.

3. I understand that while telehealth or teletherapy treatment has been found to be effective in treating a wide range of disorders, there is no guarantee that all treatment of all clients will be effective.

4. I understand that there are potential risks involving technology, including but not limited to: Internet interruptions, and technical difficulties. I understand that technical difficulties with hardware, software, and internet connection may result in service interruption and that the health care provider is not responsible for any technical problems and does not guarantee that services will be available or work as expected.

5. I understand that I am responsible for information security on my computer and in my own physical location. I understand that I am responsible for creating and maintaining my user name and password and not share these with another person. I understand that I am responsible to ensure privacy at my own location by being in a private location so other individuals cannot hear my conversation.

6. If I, or my minor child, is participating in group telehealth, I understand that every effort will be made on behalf of Pathways Counseling Services to ensure that all participants understand and abide by the confidentiality guidelines and group rules. However, it cannot be guaranteed that my privacy and confidentiality will be upheld by my fellow group participants and I am choosing to participate or allow my minor child to participate in group telehealth with Pathways Counseling Services anyway.

Please initial after reading this page: _____

7. I understand that my telehealth provider or I can discontinue the telehealth services if it is felt that this type of service delivery does not benefit my needs or for any reason whatsoever.

8. I understand that if I am participating in a 1 hour telehealth processing group that this is an ongoing weekly commitment and that the payment I provide on file will automatically be charged weekly whether I attend or not, until I cancel my enrollment at least 7 days in advance of my next group meeting. Makeup sessions will not be permitted and refunds will not be given once enrolled. Telehealth processing groups are 1 hour in length weekly and are $45 per weekly group. DBT groups are 90 minutes in length weekly and are $420 per module (6 weeks). To cancel a weekly telehealth processing group that I or my minor child is attending, I will email: info@pathwayscounselingsvcs.com.

9. I have read and understand the information provided above regarding telehealth, have discussed it with my health care provider and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth or teletherapy in my care or the care of my minor child.

Patient Consent To The Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my mental heatlh care.

I hereby authorize _____ ***Pathways Counseling Services, PLLC*** to use telehealth/teletherapy in the course of my or my minor child's diagnosis and treatment.

Signature of Patient (or legal guardian authorized to sign for patient if the patient is under 18 or has a legal guardian): _____ *Date:* _____

*If authorized signer or legal guardian, relationship to patient (in cases with joint custody, **ALL** legal guardians must sign):* _____ *Date:* _____