Center for Self Care

Courtney Poignand, LMHC#8304 774-722-5190

Information and Informed Consent for Telehealth Counseling Services

Telehealth is live two-way audio and video electronic communications to enable providers of health care and patients/clients to meet outside of the office setting for optimized service delivery when appropriate.

Client/Patient Understanding:

- **I understand that telehealth services are completely voluntary and that I can withdraw consent at any time.**
- **I understand that none of the telehealth sessions will be recorded or photographed unless I have given permission for the videotaping of sessions.**
- **I agree not to make or allow audio or video recordings of any portion of the sessions.**
- **I understand that the laws that protect privacy and confidentiality also apply to telehealth, and that no information obtained in the use of telehealth that identifies me will be disclosed to other entities without my consent.**
- **I understand that telehealth is performed over a secure communication system that is almost impossible for anyone else to access.**
- **I understand that any internet based communication is not 100% guaranteed to be secure.**
- **I agree that Courtney Poignand, LMHC will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.**
- **I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.**
- **I understand that I or Courtney Poignand may discontinue the telehealth sessions at any time if it is felt that the video technology is not adequate for the situation.**
- **I understand that if there is an emergency during a telehealth session, that Courtney Poignand may contact emergency services or my emergency contact, as needed.**
- **I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to telehealth services.**
- **I understand that if the video conferencing connections drops while I am in a session, I will have an additional phone line available to contact Courtney Poignand, or I will make additional plans to re-establish contact ahead of time to reconnect.**
- **I understand a "no-show" fee will be charged if I miss an appointment or cancel within 24 hours.**
- **I understand Courtney Poignand is using a password protected, professional ZOOM account.**
- **I hereby give my informed consent for the use of telehealthcare to the Center for Self Care.**

Signature_____**Date**_____
Client Name_____**Date of Birth**_____
Client Email_____
Client Phone_____
Address_____**City**_____**State**_____**Zip**_____
Emergency Contact_____**Relationship**_____
Emergency Phone Number(s)_____

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