CONSENT TO PARTICIPATE IN TELEHEALTH

Patient Name: ___________________________________ Medical Record No: ___________________

1. I understand that **ALTHEA LEE, LMFT** wishes me to engage in TeleHealth sessions.

2. Althea Lee, LMFT and/or office staff has explained to me that: (1) my session (s) are confidential, (2) how the video conferencing technology will be used, and that such a session will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine session if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may not be present during the sessions other than authorized individual (s). My sessions are not to be recorded, or streamed by me, provider or anyone else. I further agree that, I will inform Althea Lee, LMFT of anyone other than myself, or authorizes individual (s) are presence during the session.

5. I understand that billing will occur, and that I am responsible for visits not authorized or covered by my insurance. Also I am aware that I am responsible for my co-pay, and that my co-pay is due at the time of the session, if applicable.

6. I have had a conversation with Althea Lee, LMFT and or office staff, during which I had the opportunity to ask questions in regard to TeleHealth session. My questions have been answered and the risks, benefits have been discussed with me in a language in which I understand.

7. I have had TeleHealth explained to me, and I am choosing to participate in TeleHealth sessions.

BY SIGNING THIS FORM, I CERTIFY:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of TeleHealth
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

___________________________________ _______________ _____________

Patient's/parent/guardian signature **Date** **Time**