Telehealth Consent

Telehealth defined-
Telehealth services means the remote delivery of health care services via technology assisted media. This includes a wide of clinical services and forms of technology. The technology includes but is not limited to video, internet, smartphone, tablet, PC desktop or other electronic means.

Limitations of Telehealth-
While telehealth offers several advantages such as convenience, it is an alternative form of care and may involve disadvantages and limitations. For example, there may be a disruption of service (Video drops, wi-fi glitches). This can be frustrating and interrupt the normal flow of personal interaction. There is a risk for misunderstanding one another communication lacks visual or auditory cues. I might not pick up on tone of voice changes that would be apparent if we met in person. As a behavioral health clinician, I take every precaution to insure technologically secure and environmentally private session.

Client Responsibilities for Telehealth Services-

The virtual sessions can only be conducted when the client is within the state of Texas. The virtual sessions should be conducted on a wi-fi connection for the best connectivity and to minimize disruptions. It is recommended that you only communicate through a device that you know if safe and technologically secure (has a firewall, anti-virus software installed etc). mAs the client, you are responsible for finding a private, quiet location where the sessions may be conducted.

Address that you plan to access Telehealth Services Are-

In case of technology failure-

I understand that during Telehealth sessions we may encounter a technological failure or difficulties with hardware, software, equipment, and/or supplied by a 3rd park may result in service interruptions. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed, please call me at 832-405-4660.

Professional Fees-
Payment and visit fees apply to Telehealth visits as they do for a regular in office based on my normal fee structure. My hourly fee is $350. You are expected to pay for each session at the time the session is held.

Cancellation Policy-
Once an appointment is scheduled, you will be required to pay for that appointment unless two full business days notice is provided (a Monday morning appointment must be cancelled by Thursday morning). Cancellations with less than 48 hours notice will be charged the full session feel. I do understand that circumstances beyond your control can arise. In specific cases the fee may be waived at my discretion. Excessive missing of appointments, whether paid or unpaid, will result in a reevaluation of our treatment contract.

Contacting Me-

I am not often available immediately via phone. When I am unavailable my phone will be answered via voicemail. I am more readily able to return text messages and/or email. While my email is secure, text messages are as secure as they can be. I make every effort to return messages within 24-48 hours. If you are requesting a prescription refill, please be aware that i require 48 hours notice to do so, and on weekends, unless it is an emergency, prescriptions will not be refilled until the following week.

Emergencies-
If you are in crisis, please proceed to an emergency room or call 911. If I am concerned about you, if I lose contact with you. or if you fail to show for a scheduled appointment, I will reach out to you to check on your well-being. In addition, if you are showing signs of your safety being in trouble, I require that I have permission to contact someone to ensure your safety.

Personal Contact- personal contact can be a parent, spouse, sibling, or friend with whom you have on-going contact
Name-
Relationship-
Phone number-

Consent to treatment-
By signing the telehealth informed consent, you voluntarily agree to receive mental health assessment, care, treat,ent and services, and authorize the doctor to provide such care, treatment, or services as are considered necessary and advisable, Signing indicates you understand and agree that you will participate in the planning of your care, treat,ent, or services, and that you may terminate care, treatment, or services at any time;

_____
Signature of Client

Date:

_____
Printed name of client