Private Practice of Katharine Townsend, Ph.D. Telehealth Disclosure
Telehealth Informed Consent

I hereby consent to engage in Telehealth (e.g. internet, email, telephone, or audio-video based therapy and/or communication) with Katharine Townsend, Ph.D. I understand that Telehealth includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education, using interactive audio, video, and/or data communications. I understand that Telehealth also involves the communication of my health information, both verbally and/or visually, to other health care practitioners.

I understand that I have the following rights with respect to Telehealth:

1. I have the *right to withhold or withdraw consent* at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any benefits to which I would otherwise be entitled.
2. The laws that protect the *confidentiality* of my medical information also apply to Telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and disabled/dependent adult abuse, expressed threats of violence towards an identifiable victim, and where I make my mental or emotional state an issue in a legal proceeding. (See also Practice Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details on confidentiality and other issues.) I understand that there is no permanent video or voice recording kept of any Telehealth session. I understand that nobody will record the telehealth session without the permission from the other person(s). The dissemination to researchers or other entities, of any personally identifiable images or information from the Telehealth interaction shall not occur without my written consent. All existing confidentiality protections apply.
3. I understand that there are *risks* to using Telehealth. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychologist, that: the transmission of my health information could be disrupted or distorted by technical failures, the transmission of my medical information could be interrupted by unauthorized persons, the electronic storage of my health information could be accessed by unauthorized persons, and/or misunderstandings can more easily occur, especially when communication occurs in an asynchronous manner. I understand that my psychologist uses HIPAA-compliant platforms to discuss my health information with me. I understand that Telehealth services and care may not yield the same results nor be as complete as face-to-face services. I understand that my psychologist believes I would be better served by another form of psychotherapeutic service (e.g. face-to- face), I will be encouraged to meet in person for appointments, or I will be referred to a provider whom my psychologist believes is better suited to meet my needs. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that, despite my efforts and the efforts of my psychologist, my condition may not improve and in some cases my even get worse.
4. I understand that I need to *use a webcam or smartphone* during the telehealth session.
5. I understand that it is important to *be in a quiet, private space* that is free of distractions (including cell phone or other devices) during the session.
6. I understand the importance of *using a secure internet connection rather* than public/free Wi-Fi.
7. I understand that it is important to *be on time*. If I need to cancel or change my tele-appointment, I will notify the psychologist at least 24 hours in advance by phone or email.
8. I understand the importance of a *back-up plan* (e.g., phone number where I can be reached) to restart the session or to reschedule it, in the event of technical problems.
9. I understand that I will need a *safety plan* that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
10. I understand that I may *benefit* from Telehealth, but results cannot be guaranteed or assured. The benefits of Telehealth may include, but are not limited to: finding a greater ability to express thoughts and

emotions, transportation and travel difficulties are avoided, time constraints are minimized, and there may be a greater opportunity to prepare in advance for therapy sessions.

11. I understand that it is *my responsibility to verify my coverage* with my insurance plan, and I am responsible for fees for this service if my insurance does not cover Telehealth. I am responsible for all copayment or noncovered fees. I understand that insurance does not cover telephone sessions.
12. All existing laws regarding client access to mental health information and copies of mental health records apply. I understand that I have the right to access my health information and copies of my health records in accordance with Massachusetts law, and that these services may not be covered by insurance.

I have had an opportunity to ask questions about this information, and all of my questions have been answered to my satisfaction. I understand the written information provided above.

Psychologist Name / Signature: ____

Patient Name: ____

Signature of Patient/Patient's Legal Representative: ______________________________

Date: __________________