Vitman Counseling LLC

Consent to Participate in Telehealth Counseling

Client Name _____ Date _____

1. For the health reasons, I wish to engage in a telehealth counseling with my therapist Spomenka Vitman, MA LMHC.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a counselling will not be the same as a direct client/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 telehealth consult/visit 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 also be present during the consultation other than my health care provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth conference: and or (3) terminate the consultation at any time.
5. I have had the alternatives to a telehealth consultation explained to me, and in choosing to participate in a telehealth counseling.
6. I understand that billing will occur as a telehealth counseling and I understand that if, for any reason, my insurance company does not pay my fee, I am responsible for the entire amount.
7. I have had a direct conversation with my therapist, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

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 the telehealth counseling.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Client's/parent/guardian signature	Date	Time
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