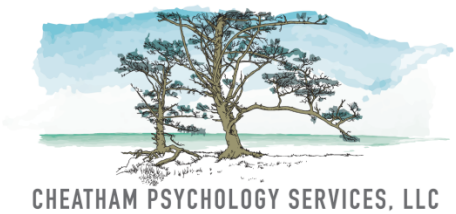

www.cheathampsychology.com

Phone (971) 277-9984/Fax (971) 266-2834

cheathampsychologyservices@gmail.com

INFORMED CONSENT FOR TELEHEALTH

Patient Name: _____

Agreement and Informed Consent for Telehealth Services

If you have been invited to participate in telehealth services with Cheatham Psychology Services LLC, please be advised that we use a secure, HIPAA-compliant video conference software program in order to protect your confidentiality.

Be informed that even secure transmission of information online is potentially vulnerable to interception by unauthorized parties.

Please be aware that it is your responsibility to take steps to preserve your privacy by using a non-shared computer for sessions, using a strong password for your account if required, and connecting via a secure network.

If you have concerns about the confidentiality of telehealth participation, please discuss this with your provider.

Nobody will record your session without your permission.

You agree to use the video-conferencing platform selected for our virtual sessions, and your practitioner will explain how to use it.

You need to use a webcam or smartphone during the session. You and your practitioner must be able to see and hear one another.

It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.

It is important to use a secure internet connection rather than public/free Wi-Fi whenever possible.

Your practitioner and you will discuss a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.

You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.

Your practitioner may determine that due to certain circumstances, telehealth is no longer appropriate and that we should resume our appointments in-person.

_____ (Initial Here) I consent to use secure video conference software for telehealth sessions. I am aware of the risks of using even secure means of video communication to transmit my protected health information.

_____ (Initial Here) I also consent for Cheatham Psychology Services LLC to contact my Emergency Contact or the local Crisis Line if my therapist feels that I am in a real or potential crisis that could affect the healthy or safety of myself or others.

_____ (Initial Here) I understand that this "Informed Consent for Telehealth" is in addition to the "Informed Consent Signature Page" which I have already reviewed and signed.

Patient Signature_____ Date_____